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SENATE

REPORT
103–136

VETERANS HEALTH PROGRAMS IMPROVEMENT ACT OF 1993

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 1030

together with

MINORITY VIEWS

SEPTEMBER 8 (legislative day, SEPTEMBER 7), 1993.—Ordered to be printed

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VETERANS HEALTH PROGRAMS IMPROVEMENT ACT OF 1993

SEPTEMBER 8 (legislative day, SEPTEMBER 7), 1993.—Ordered to be printed

Mr. ROCKEFELLER, from the Committee on Veterans' Affairs, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 1030]

The Committee on Veterans' Affairs, to which was referred the bill (S. 1030) to amend chapter 17 of title 38, United States Code, to improve the Department of Veterans Affairs program of sexual trauma counseling for veterans and to improve certain Department of Veterans Affairs programs for women veterans, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

COMMITTEE BILL

The text of the bill as reported is as follows:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans Health Programs Improvement Act of 1993".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—WOMEN VETERANS

SEC. 101. DEPARTMENT OF VETERANS AFFAIRS SEXUAL TRAUMA SERVICES PROGRAM.

(a) AUTHORITY TO PROVIDE SERVICES FOR SEXUAL TRAUMA.—(1) Subsection (a)(1) of section 1720D of title 38, United States Code is amended—

(1) by inserting "(A)" before "During the period"; and

(2) by adding at the end the following:

"(B) During the period referred to in subparagraph (A), the Secretary may provide appropriate care and services to a veteran for an injury, illness, or other psychological condition which the Secretary determines to be the result of a physical assault, battery, or harassment referred to in that subparagraph.".

(2) Subsection (c)(1) of such section is amended to read as follows:

"(1) The Secretary shall give priority to the establishment and operation of the program to provide counseling and care and services under subsection (a). In the case of a veteran eligible for counseling and care and services under subsection (a)(1), the Secretary shall ensure that the veteran is furnished counseling under this section in a way that is coordinated with the furnishing of such care and services under this chapter.".

(3) Subsection (d) of such section is amended by inserting "and care and services" after "counseling" each place it appears.

(b) AUTHORITY TO PROVIDE SERVICES BY CONTRACT.—Subsection (a)(3) of such section is amended—

(1) by inserting "(A)" before "In furnishing";

(2) in subparagraph (A), as so designated—

(i) by striking out "(A)" and inserting in lieu thereof "(i)"; and

(ii) by striking out "(B)" and inserting in lieu thereof "(ii)"; and

(3) by adding at the end the following:

"(B) The Secretary may provide care and services to a veteran under paragraph (1)(B) pursuant to a contract with a qualified non-Department health professional or facility if Department facilities are not capable of furnishing such care and services to that veteran economically because of geographic inaccessibility.".

(c) EXTENSION OF AUTHORITY TO PROVIDE SEXUAL TRAUMA SERVICES.—Subsection (a) of such section, as amended by subsections (a) and (b) of this section, is further amended—

(1) by striking out "December 31, 1995," in paragraph (1)(A) and inserting in lieu thereof "December 31, 1998,"; and

(2) by striking out "December 31, 1994," in paragraph (3) and inserting in lieu thereof "December 31, 1998,".

(d) PERIOD OF ELIGIBILITY TO SEEK SERVICES.—(1) Such subsection, as amended by subsections (a), (b), and (c) of this section, is further amended—

(A) by striking out paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2).

(2) Section 102(b) of the Veterans Health Care Act of 1992 (Public Law 102–585; 106 Stat. 4946; 38 U.S.C. 1720D note) is repealed.

(e) REPEAL OF LIMITATION ON PERIOD OF RECEIPT OF SERVICES.—Section 1720D of title 38, United States Code (as amended by subsections (a) through (d) of this section), is further amended—

(1) by striking out subsection (b); and

(2) by redesignating subsections (c), (d), and (e) as subsections (b), (c), and (d), respectively.

(f) INCREASED PRIORITY OF CARE.—Section 1712(i) of title 38, United States Code, is amended—

(1) in paragraph (1)—

(A) by inserting "(A)" after "To a veteran"; and

(B) by inserting ", or (B) who is eligible for counseling and care and services under section 1720D of this title, for the purposes of such counseling and care and services" before the period at the end; and

(2) in paragraph (2)—

(A) by striking out ", (B)" and inserting in lieu thereof "or (B)"; and

(B) by striking out ", or (C)" and all that follows through "such counseling".

(g) PROGRAM REVISION.—(1) Section 1720D of title 38, United States Code (as amended by subsections (a) through (e) of this section), is further amended—

(A) by striking out "woman" in subsection (a)(1)(A);

(B) by striking out "women" in subsection (b)(2)(C) and in the first sentence of subsection (c); and

(C) by striking out "women" in subsection (c)(2) and inserting in lieu thereof "individuals".

(2)(A) The heading of such section is amended to read as follows:

"§ 1720D. Counseling, care, and services for sexual trauma".

(B) The item relating to such section in the table of sections at the beginning of chapter 17 of such title is amended to read as follows:

"1720D. Counseling, care, and services for sexual trauma."

(h) INFORMATION ON COUNSELING BY TELEPHONE.—(1) Paragraph (1) of section 1720D(c) of title 38, United States Code, as redesignated by subsection (d) of this section, is amended by striking out "may" and inserting in lieu thereof "shall".

(2) In providing information on counseling available to veterans through the information system required under section 1720D(c)(1) of title 38, United States Code, as amended by this section, the Secretary of Veterans Affairs shall ensure—

(A) that the telephone system described in such section is operated by Department of Veterans Affairs personnel who are trained in the provision to persons who have experienced sexual trauma of information about the counseling and care and services relating to sexual trauma that are available to veterans in the communities in which such veterans reside, including counseling and care and services available under programs of the Department (including the care and services available under section 1720D of such title) and from non-Department agencies or organizations;

(B) that such personnel are provided with information on the counseling and care and services relating to sexual trauma that are available to veterans and the locations in which such care and services are available;

(C) that such personnel refer veterans seeking such counseling and care and services to appropriate providers of such counseling and care and services (including counseling and care and services that are available in the communities in which such veterans reside);

(D) that the telephone system is operated in a manner that protects the confidentiality of persons who place telephone calls to the system; and

(E) that the telephone system operates at all times.

(3) The Secretary shall ensure that information about the availability of the telephone system is visibly posted in Department medical facilities and is advertised through public service announcements, pamphlets, and other means.

(4) Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the operation of the telephone system required under section 1720D(c)(1) of title 38, United States Code (as so amended). The report shall set forth the following:

(A) The number of telephone calls placed to the system during the period covered by the report, with a separate display of (i) the number of calls placed to the system from each State (as such term is defined in section 101(20) of title 38, United States Code) during that period, and (ii) the number of persons who placed more than one call to the system during that period.

(B) The types of sexual trauma described to personnel operating the system by persons placing calls to the system.

(C) A description of the difficulties, if any, experienced by persons placing calls to the system in obtaining counseling and care and services for sexual trauma in the communities in which such persons live, including counseling and care and services available from the Department and from non-Department agencies and organizations.

(D) A description of the training provided to the personnel operating the system.

(E) The recommendations and plans of the Secretary for the improvement of the system.

(5) The Secretary shall commence operation of the telephone system required under section 1720D(c)(1) of title 38, United States Code (as so amended), not later than 180 days after the date of the enactment of this Act.

SEC. 102. REPORTS RELATING TO DETERMINATIONS OF SERVICE CONNECTION FOR SEXUAL TRAUMA.

(a) REPORT.—(1) The Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing the Secretary's assessment of—

(A) the difficulties that veterans encounter in obtaining from the Department of Veterans Affairs determinations that disabilities relating to sexual trauma resulting from events that occurred during active duty are service-connected disabilities; and

(B) the extent to which Department personnel fail to make determinations that such disabilities are service-connected disabilities.

(2) The Secretary shall include in the report the Secretary's recommendations for actions to be taken to respond in a fair manner to the difficulties described in the report and to eliminate failures to make determinations that such disabilities are service-connected disabilities.

(3) The report required by this subsection shall be submitted not later than June 30, 1994.

(b) FOLLOW-UP REPORTS.—Not later than June 30 of each of 1995 and 1996, the Secretary shall submit to the committees referred to in paragraph (1) of subsection (a) a report on the actions taken by the Secretary to implement the recommendations referred to in paragraph (2) of that subsection.

(c) DEFINITION.—In this section, the term "sexual trauma" means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, aggravated sexual abuse (as such term is described in section 2241 of title 18, United States Code), sexual harassment, or other act of sexual violence.

SEC. 103. COORDINATORS OF WOMEN'S SERVICES.

(a) REQUIREMENT OF FULL-TIME SERVICE.—Section 108 of the Veterans Health Care Act of 1992 (Public Law 102–585; 106 Stat. 4948; 38 U.S.C. 1710 note) is amended—

(1) by inserting "(a)" before "The Secretary"; and

(2) by adding at the end the following:

"(b) Each official who serves in the position of coordinator of women's services under subsection (a) shall so serve on a full-time basis.".

(b) ADDITIONAL RESPONSIBILITIES.—Subsection (a) of such section (as designated by subsection (a) of this section) is further amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph (5):

"(5) Facilitating communication between women veterans coordinators under the jurisdiction of such regional coordinator and the Under Secretary for Health and the Secretary.".

(c) SUPPORT FOR WOMEN'S SERVICES COORDINATORS.—The Secretary of Veterans Affairs shall take appropriate actions to ensure that—

(1) sufficient funding is provided to each Department of Veterans Affairs facility in order to permit the coordinator of women's services to carry out the responsibilities of the coordinator at the facility;

(2) sufficient clerical and communications support is provided to each such coordinator for that purpose; and

(3) each such coordinator has direct access to the Director or Chief of Staff of the facility to which the coordinator is assigned.

SEC. 104. WOMEN'S HEALTH SERVICES.

(a) WOMEN'S HEALTH SERVICES.—Section 1701 of title 38, United States Code, is amended—

(1) in paragraph (6)(A)(i), by inserting "women's health services," after "preventive health services,"; and

(2) by adding at the end the following:

"(10) The term 'women's health services' means health care services provided to women, including counseling and services relating to the following:

"(A) Papanicolaou tests (pap smear).

"(B) Breast examinations and mammography.

"(C) Comprehensive reproductive health care, including pregnancy-related care.

"(D) The management of infertility.

"(E) The management and prevention of sexually-transmitted diseases.

"(F) Menopause.

"(G) Physical or psychological conditions arising out of acts of sexual violence.".

(b) CONTRACTS FOR WOMEN'S HEALTH SERVICES.—Section 1703(a) of such title is amended by adding at the end the following:

"(9) Women's health services for veterans on an ambulatory or outpatient basis.".

(c) REPEAL OF SUPERSEDED AUTHORITY.—Section 106 of the Veterans Health Care Act of 1992 (Public Law 102–585; 38 U.S.C. 1710 note) is amended—

(1) by striking out subsection (a); and

(2) by striking out "(b) RESPONSIBILITIES OF DIRECTORS OF FACILITIES.—" before "The Secretary".

(d) REPORT ON HEALTH CARE AND RESEARCH.—Section 107(b) of such Act (38 U.S.C. 1710 note) is amended—

(1) in paragraph (1), by inserting "and women's health services (as such term is defined in section 1701(10) of title 38, United States Code)" after "section 106 of this Act";

(2) in paragraph (2), by striking out "and (B)" and inserting in lieu thereof "(B) the type and amount of services provided by such personnel, including information on the numbers of inpatient stays and the number of outpatient visits through which such services were provided, and (C)";

(3) by redesignating paragraph (4) as paragraph (7);

(4) by adding after paragraph (3) the following new paragraphs:

"(4) A description of the personnel of the Department who provided such services to women veterans, including the number of employees (including both the number of individual employees and the number of full-time employee equivalents) and the professional qualifications or specialty training of such employees and the Department facilities to which such personnel were assigned.

"(5) A description of any actions taken by the Secretary to ensure the retention of the personnel described in paragraph (4), and any actions undertaken to recruit additional such personnel or personnel to replace such personnel.

"(6) An assessment by the Secretary of any difficulties experienced by the Secretary in the furnishing of such services and the actions taken by the Secretary to resolve such difficulties."; and

(5) by adding after paragraph (7), as redesignated by paragraph (3) of this subsection, the following:

"(8) A description of the actions taken by the Secretary to foster and encourage the expansion of such research.".

SEC. 105. EXPANSION OF RESEARCH RELATING TO WOMEN VETERANS.

(a) HEALTH RESEARCH.—Section 109(a) of the Veterans Health Care Act of 1992 (Public Law 102–585; 38 U.S.C. 7303 note) is amended—

(1) by inserting "(1)" before "The Secretary";

(2) in paragraph (1), as so designated, by striking out "veterans who are women" and inserting in lieu thereof "women veterans"; and

(3) by adding at the end the following:

"(2) In carrying out this section, the Secretary shall consult with the following:

"(A) The Director of the Nursing Service.

"(B) Officials of the Central Office assigned responsibility for women's health programs and sexual trauma services.

"(C) The members of the Advisory Committee on Women Veterans established under section 542 of title 38, United States Code.

"(D) Members of appropriate task forces and working groups within the Department of Veterans Affairs (including the Women Veterans Working Group and the Task Force on Treatment of Women Who Suffer Sexual Abuse).

"(3) The Secretary shall foster and encourage research under this section on the following matters as they relate to women:

"(A) Breast cancer.

"(B) Gynecological and reproductive health, including gynecological cancer, infertility, sexually-transmitted diseases, and pregnancy.

"(C) Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

"(D) Mental health, including post-traumatic stress disorder and depression.

"(E) Diseases related to aging, including menopause, osteoporosis, and Alzheimer's Disease.

"(F) Substance abuse.

"(G) Sexual violence and related trauma.

"(H) Exposure to toxic chemicals and other environmental hazards.

"(4) The Secretary shall, to the maximum extent practicable, ensure that personnel of the Department of Veterans Affairs engaged in the research referred to in paragraph (1) include the following:

"(A) Personnel of the geriatric research, education, and clinical centers designated pursuant to section 7314 of title 38, United States Code.

"(B) Personnel of the National Center for Post-Traumatic Stress Disorder established pursuant to section 110(c) of the Veterans Health Care Act of 1984 (Public Law 98–528; 98 Stat. 2692).

"(5) The Secretary shall, to the maximum extent practicable, ensure that personnel of the Department engaged in research relating to the health of women veterans are advised and informed of such research engaged in by other personnel of the Department.".

(b) POPULATION STUDY.—Section 110(a) of such Act (38 U.S.C. 1710 note) is amended—

(1) in paragraph (1), by striking out the second sentence; and

(2) by amending paragraph (3) to read as follows:

"(3)(A) Subject to subparagraph (B), the study shall be based on—

"(i) an appropriate sample of veterans who are women and of women who are serving on active military, naval, or air service; and

"(ii) an examination of the medical and demographic histories of the women comprising such sample.

"(B) The sample referred to in subparagraph (A) shall, to the maximum extent practicable, constitute a representative sampling (as determined by the Secretary) of the ages, the ethnic, social and economic backgrounds, the enlisted and officer grades, and the branches of service of all veterans who are women and women who are serving on such duty.

"(C) In carrying out the examination referred to in subparagraph (A)(ii), the Secretary shall determine the number of women of the sample who have used medical facilities of the Department, nursing home facilities of or under the jurisdiction of the Department, and outpatient care facilities of or under the jurisdiction of the Department.".

SEC. 106. MAMMOGRAPHY QUALITY STANDARDS.

(a) PERFORMANCE OF MAMMOGRAMS.—Mammograms may not be performed at a Department of Veterans Affairs facility unless that facility is accredited for that purpose by a private nonprofit organization designated by the Secretary of Veterans Affairs. The organization designated by the Secretary under this subsection shall meet the standards for accrediting bodies established by the Secretary of Health and Human Services under section 354(e) of the Public Health Service Act (42 U.S.C. 263b(e)).

(b) QUALITY STANDARDS.—(1)(A) The Secretary of Veterans Affairs shall prescribe quality assurance and quality control standards relating to the performance and interpretation of mammograms and use of mammogram equipment and facilities by personnel of the Department of Veterans Affairs. Such standards shall be no less stringent than the standards prescribed by the Secretary of Health and Human Services under section 354(f) of the Public Health Service Act.

(B) In prescribing such standards, the Secretary of Veterans Affairs shall consult with the Secretary of Health and Human Services.

(2) The Secretary of Veterans Affairs shall prescribe such standards not later than 120 days after the Secretary of Health and Human Services prescribes quality standards under such section 354(f).

(c) INSPECTION OF DEPARTMENT EQUIPMENT.—(1) The Secretary of Veterans Affairs shall, on an annual basis, inspect the equipment and facilities utilized by and in Department of Veterans Affairs health-care facilities for the performance of mammograms in order to ensure the compliance of such equipment and facilities with the standards prescribed under subsection (b). Such inspection shall be carried out in a manner consistent with the inspection of certified facilities by the Secretary of Health and Human Services under section 354(g) of the Public Health Services Act.

(2) The Secretary of Veterans Affairs may not delegate the responsibility of such secretary under paragraph (1) to a State agency.

(d) APPLICATION OF STANDARDS TO CONTRACT PROVIDERS.—The Secretary of Veterans Affairs shall ensure that mammograms performed for the Department of Veterans Affairs under contract with any non-Department facility or provider conform to the quality standards prescribed by the Secretary of Health and Human Services under section 354 of the Public Health Service Act.

(e) REPORT.—(1) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the quality standards prescribed by the Secretary under subsection (b)(1).

(2) The Secretary shall submit the report not later than 180 days after the date on which the Secretary prescribes such regulations.

(f) DEFINITION.—In this section, the term "mammogram" shall have the meaning given such term in section 354(a)(5) of the Public Health Service Act (42 U.S.C. 263b(a)).

TITLE II—GENERAL HEALTH CARE SERVICES

SEC. 201. EXTENSION OF PERIOD OF ELIGIBILITY FOR MEDICAL CARE FOR EXPOSURE TO DIOXIN OR IONIZING RADIATION.

Section 1710(e)(3) of title 38, United States Code, is amended by striking out "December 31, 1993" and inserting in lieu thereof "December 31, 2003".

SEC. 202. AUTHORITY TO PROVIDE PRIORITY HEALTH CARE TO VETERANS OF THE PERSIAN GULF WAR.

(a) AUTHORIZED INPATIENT CARE.—(1) Section 1710(a)(1)(G) of title 38, United States Code, is amended by striking out "or radiation" and inserting in lieu thereof ", radiation, or environmental hazard".

(2) Section 1710(e) of such title is amended—

(A) by inserting at the end of paragraph (1) the following new subparagraph:

"(C) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard (including petrochemicals, the fumes of burning landfills or petrochemicals, pharmaceuticals or other chemical agents administered by the Department of Defense, indigenous diseases, pesticides, and inhalation or ingestion of depleted uranium or wounds caused by depleted uranium) is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.";

(B) in paragraph (2), by striking out "subparagraph (A) or (B)" and inserting in lieu thereof "subparagraph (A), (B), or (C)"; and

(C) in paragraph (3), by striking out the period at the end and inserting in lieu thereof ", or, in the case of care for a veteran described in paragraph (1)(C), after September 30, 2003.".

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712(a) of such title is amended—

(1) in paragraph (1)—

(A) by striking out "and" at the end of subparagraph (B);

(B) by striking out the period at the end of subparagraph (C) and inserting in lieu thereof "; and"; and

(C) by adding at the end the following:

"(D) during the period before October 1, 2003, for any disability in the case of a veteran who served on active duty in the Southwest Asia theater of operations during the Persian Gulf War and who the Secretary finds may have been exposed to a toxic substance or environmental hazard (including petrochemicals, the fumes of burning landfills or petrochemicals, pharmaceuticals or other chemical agents administered by the Department of Defense, indigenous diseases, pesticides, and inhalation or ingestion of depleted uranium or wounds caused by depleted uranium) during such service, notwithstanding that

there is insufficient medical evidence to conclude that the disability may be associated with such exposure."; and

(2) by adding at the end the following new paragraph:

"(7) Medical services may not be furnished under paragraph (1)(D) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in that paragraph.".

(c) EFFECTIVE DATE.—(1) The amendments made by subsections (a) and (b) shall take effect as of August 2, 1990.

(2) The Secretary of Veterans Affairs shall, upon request, reimburse any veteran who paid the United States an amount under section 1710(f) or 1712(f) of title 38, United States Code, as the case may be, for hospital care, nursing home care, or outpatient services, as the case may be, furnished by the Secretary to the veteran before the date of the enactment of this Act as a result of the exposure of the veteran to a toxic substance or environmental hazards during the Persian Gulf War. The amount of the reimbursement shall be the amount paid by the veteran for such care or services under such section 1710(f) or 1712(f).

SEC. 203. PROGRAMS FOR FURNISHING HOSPICE CARE TO VETERANS.

(a) ESTABLISHMENT OF PROGRAMS.—Chapter 17 of title 38, United States Code, is amended by adding at the end the following:

"SUBCHAPTER VII—HOSPICE CARE PILOT PROGRAM; HOSPICE CARE SERVICES

"§ 1761. Definitions

"For the purposes of this subchapter—

"(1) The term 'terminally ill veteran' means any veteran—

"(A) who is (i) entitled to receive hospital care in a medical facility of the Department under section 1710(a)(1) of this title, (ii) eligible for hospital or nursing home care in such a facility and receiving such care, (iii) receiving care in a State home facility for which care the Secretary is paying per diem under section 1741 of this title, or (iv) transferred to a non-Department nursing home for nursing home care under section 1720 of this title and receiving such care; and

"(B) who has a medical prognosis (as certified by a Department physician) of a life expectancy of six months or less.

"(2) The term 'hospice care services' means (A) the care, items, and services referred to in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and (B) personal care services.

"(3) The term 'hospice program' means any program that satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

"(4) The term 'medical facility of the Department' means a facility referred to in section 1701(4)(A) of this title.

"(5) The term 'non-Department facility' means a facility (other than a medical facility of the Department) at which care to terminally ill veterans is furnished, regardless of whether

such care is furnished pursuant to a contract, agreement, or other arrangement referred to in section 1762(b)(1)(D) of this title.

"(6) The term 'personal care services' means any care or service furnished to a person that is necessary to maintain a person's health and safety within the home or nursing home of the person, including care or services related to dressing and personal hygiene, feeding and nutrition, and environmental support.

"§ 1762. Hospice care: pilot program requirements

"(a)(1) During the period beginning on October 1, 1993, and ending on December 31, 1998, the Secretary shall conduct a pilot program in order—

"(A) to assess the feasibility and desirability of furnishing hospice care services to terminally ill veterans; and

"(B) to determine the most efficient and effective means of furnishing such services to such veterans.

"(2) The Secretary shall conduct the pilot program in accordance with this section.

"(b)(1) Under the pilot program, the Secretary shall—

"(A) designate not less than 15 nor more than 30 medical facilities of the Department at or through which to conduct hospice care services demonstration projects;

"(B) designate the means by which hospice care services shall be provided to terminally ill veterans under each demonstration project pursuant to subsection (c);

"(C) allocate such personnel and other resources of the Department as the Secretary considers necessary to ensure that services are provided to terminally ill veterans by the designated means under each demonstration project; and

"(D) enter into any contract, agreement, or other arrangement that the Secretary considers necessary to ensure the provision of such services by the designated means under each such project.

"(2) In carrying out the responsibilities referred to in paragraph (1) the Secretary shall take into account the need to provide for and conduct the demonstration projects so as to provide the Secretary with such information as is necessary for the Secretary to evaluate and assess the furnishing of hospice care services to terminally ill veterans by a variety of means and in a variety of circumstances.

"(3) In carrying out the requirement described in paragraph (2), the Secretary shall ensure, to the maximum extent feasible, that—

"(A) the medical facilities of the Department selected to conduct demonstration projects under the pilot program include facilities located in urban areas of the United States and rural areas of the United States;

"(B) the full range of affiliations between medical facilities of the Department and medical schools is represented by the facilities selected to conduct demonstration projects under the pilot program, including no affiliation, minimal affiliation, and extensive affiliation;

"(C) such facilities vary in the number of beds that they operate and maintain; and

"(D) the demonstration projects are located or conducted in accordance with any other criteria or standards that the Secretary considers relevant or necessary to furnish and to evaluate and assess fully the furnishing of hospice care services to terminally ill veterans.

"(c)(1) Subject to paragraph (2), hospice care to terminally ill veterans shall be furnished under a demonstration project by one or more of the following means designated by the Secretary:

"(A) By the personnel of a medical facility of the Department providing hospice care services pursuant to a hospice program established by the Secretary at that facility.

"(B) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a medical facility of the Department.

"(C) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a non-Department medical facility.

"(2)(A) The Secretary shall provide that—

"(i) care is furnished by the means described in paragraph (1)(A) at not less than five medical facilities of the Department; and

"(ii) care is furnished by the means described in subparagraphs (B) and (C) of paragraph (1) in connection with not less than five such facilities for each such means.

"(B) The Secretary shall provide in any contract under subparagraph (B) or (C) of paragraph (1) that inpatient care may be provided to terminally ill veterans at a medical facility other than that designated in the contract if the provision of such care at such other facility is necessary under the circumstances.

"(d)(1) Except as provided in paragraph (2), the amount paid to a hospice program for care furnished pursuant to subparagraph (B) or (C) of subsection (c)(1) may not exceed the amount that would be paid to that program for such care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) if such care were hospice care for which payment would be made under part A of title XVIII of such Act.

"(2) The Secretary may pay an amount in excess of the amount referred to in paragraph (1) (or furnish services whose value, together with any payment by the Secretary, exceeds such amount) to a hospice program for furnishing care to a terminally ill veteran pursuant to subparagraph (B) or (C) of subsection (c)(1) if the Secretary determines, on a case-by-case basis, that—

"(A) the furnishing of such care to the veteran is necessary and appropriate; and

"(B) the amount that would be paid to that program under section 1814(i) of the Social Security Act would not compensate the program for the cost of furnishing such care.

"§ 1763. Care for terminally ill veterans

"(a) During the period referred to in section 1762(a)(1) of this title, the Secretary shall designate not less than 10 medical facilities of the Department at which hospital care is being furnished to terminally ill veterans to furnish the care referred to in subsection (b)(1).

"(b)(1) Palliative care to terminally ill veterans shall be furnished at the facilities referred to in subsection (a) by one of the following means designated by the Secretary:

"(A) By personnel of the Department providing one or more hospice care services to such veterans at or through medical facilities of the Department.

"(B) By personnel of the Department monitoring the furnishing of one or more of such services to such veterans at or through non-Department facilities.

"(2) The Secretary shall furnish care by the means referred to in each of subparagraphs (A) and (B) of paragraph (1) at not less than five medical facilities designated under subsection (a).

"§ 1764. Information relating to hospice care services

"The Secretary shall ensure to the extent practicable that terminally ill veterans who have been informed of their medical prognosis receive information relating to the eligibility, if any, of such veterans for hospice care and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"§ 1765. Evaluation and reports

"(a) Not later than September 30, 1994, and on an annual basis thereafter until October 1, 1999, the Secretary shall submit a written report to the Committees on Veterans' Affairs of the Senate and House of Representatives relating to the conduct of the pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. Each report shall include the following information:

"(1) The location of the sites of the demonstration projects provided for under the pilot program.

"(2) The location of the medical facilities of the Department at or through which hospice care services are being furnished under section 1763 of this title.

"(3) The means by which care to terminally ill veterans is being furnished under each such project and at or through each such facility.

"(4) The number of veterans being furnished such care under each such project and at or through each such facility.

"(5) An assessment by the Secretary of any difficulties in furnishing such care and the actions taken to resolve such difficulties.

"(b) Not later than August 1, 1997, the Secretary shall submit to the committees referred to in subsection (a) a report containing an evaluation and assessment by the Director of the Health Services Research and Development Service of the hospice care pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. The report shall contain such information (and shall be presented in such form) as will

enable the committees to evaluate fully the feasibility and desirability of furnishing hospice care services to terminally ill veterans.

"(c) The report shall include the following:

"(1) A description and summary of the pilot program.

"(2) With respect to each demonstration project conducted under the pilot program—

"(A) a description and summary of the project;

"(B) a description of the facility conducting the demonstration project and a discussion of how such facility was selected in accordance with the criteria set out in, or prescribed by the Secretary pursuant to, subparagraphs (A) through (D) of section 1762(b)(3) of this title;

"(C) the means by which hospice care services are being furnished to terminally ill veterans under the demonstration project;

"(D) the personnel used to furnish such services under the demonstration project;

"(E) a detailed factual analysis with respect to the furnishing of such services, including (i) the number of veterans being furnished such services, (ii) the number, if any, of inpatient admissions for each veteran being furnished such services and the length of stay for each such admission, (iii) the number, if any, of outpatient visits for each such veteran, and (iv) the number, if any, of home-care visits provided to each such veteran;

"(F) the direct costs, if any, incurred by terminally ill veterans, the members of the families of such veterans, and other individuals in close relationships with such veterans in connection with the participation of veterans in the demonstration project;

"(G) the costs incurred by the Department in conducting the demonstration project, including an analysis of the costs, if any, of the demonstration project that are attributable to (i) furnishing such services in facilities of the Department, (ii) furnishing such services in non-Department facilities, and (iii) administering the furnishing of such services; and

"(H) the unreimbursed costs, if any, incurred by any other entity in furnishing services to terminally ill veterans under the project pursuant to section 1762(c)(1)(C) of this title.

"(3) An analysis of the level of the following persons' satisfaction with the services furnished to terminally ill veterans under each demonstration project:

"(A) Terminally ill veterans who receive such services, members of the families of such veterans, and other individuals in close relationships with such veterans.

"(B) Personnel of the Department responsible for furnishing such services under the project.

"(C) Personnel of non-Department facilities responsible for furnishing such services under the project.

"(4) A description and summary of the means of furnishing hospice care services at or through each medical facility of the Department designated under section 1763(a)(1) of this title.

"(5) With respect to each such means, the information referred to in paragraphs (2) and (3).

"(6) A comparative analysis by the Director of the services furnished to terminally ill veterans under the various demonstration projects referred to in section 1762 of this title and at or through the designated facilities referred to in section 1763 of this title, with an emphasis in such analysis on a comparison relating to—

"(A) the management of pain and health symptoms of terminally ill veterans by such projects and facilities;

"(B) the number of inpatient admissions of such veterans and the length of inpatient stays for such admissions under such projects and facilities;

"(C) the number and type of medical procedures employed with respect to such veterans by such projects and facilities; and

"(D) the effectiveness of such projects and facilities in providing care to such veterans at the homes of such veterans or in nursing homes.

"(7) An assessment by the Director of the feasibility and desirability of furnishing hospice care services by various means to terminally ill veterans, including an assessment by the Director of the optimal means of furnishing such services to such veterans.

"(8) Any recommendations for additional legislation regarding the furnishing of care to terminally ill veterans that the Secretary considers appropriate.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by adding at the end the following:

"SUBCHAPTER VII—HOSPICE CARE PILOT PROGRAM; HOSPICE CARE SERVICES

"1761. Definitions.
"1762. Hospice care: pilot program requirements.
"1763. Care for terminally ill veterans.
"1764. Information relating to hospice care services.
"1765. Evaluation and reports.".

(c) AUTHORITY TO CARRY OUT OTHER HOSPICE CARE PROGRAMS.—The amendments made by subsection (a) may not be construed as terminating the authority of the Secretary of Veterans Affairs to provide hospice care services to terminally ill veterans under any program in addition to the programs required under the provisions added by such amendments.

(d) AUTHORIZATION OF APPROPRIATIONS.—Funds are authorized to be appropriated for the Department of Veterans Affairs for the purposes of carrying out the evaluation of the hospice care pilot programs under section 1765 of title 38, United States Code (as added by subsection (a)), as follows:

(1) For fiscal year 1994, $1,200,000.
(2) For fiscal year 1995, $2,500,000.
(3) For fiscal year 1996, $2,200,000.
(4) For fiscal year 1997, $100,000.

SEC. 204. RURAL HEALTH-CARE CLINIC PROGRAM.

(a) PROGRAM.—(1) Chapter 17 of title 38, United States Code, is amended by adding at the end of subchapter II the following:

"§ 1720E. Rural health-care clinics: pilot program

"(a) During the three-year period beginning on October 1, 1993, the Secretary shall conduct a rural health-care clinic program in States where significant numbers of veterans reside in areas geographically remote from existing health-care facilities (as determined by the Secretary). The Secretary shall conduct the program in accordance with this section.

"(b)(1) In carrying out the rural health-care clinic program, the Secretary shall furnish medical services to the veterans described in subsection (c) through use of—

"(A) mobile health-care clinics equipped, operated, and maintained by personnel of the Department; and

"(B) other types of rural clinics, including part-time stationary clinics for which the Secretary contracts and part-time stationary clinics operated by personnel of the Department.

"(2) The Secretary shall furnish services under the rural health-care clinic program in areas—

"(A) that are more than 100 miles from a Department general health-care facility; and

"(B) that are less than 100 miles from such a facility, if the Secretary determines that the furnishing of such services in such areas is appropriate.

"(c) A veteran eligible to receive medical services through rural health-care clinics under the program is any veteran eligible for medical services under section 1712 of this title.

"(d) The Secretary shall commence operation of at least three rural health-care clinics (at least one of which shall be a mobile health-care clinic) in each fiscal year of the program. The Secretary may not operate more than one mobile health-care clinic under the authority of this section in any State in any such fiscal year.

"(e) Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the Secretary's plans for the implementation of the pilot program required under this section.

"(f) Not later than December 31, 1997, the Secretary shall submit to Congress a report containing an evaluation of the program. The report shall include the following:

"(1) A description of the program, including information with respect to—

"(A) the number and type of rural health-care clinics operated under the program;

"(B) the States in which such clinics were operated;

"(C) the medical services furnished under the program, including a detailed specification of the cost of such services;

"(D) the veterans who were furnished services under the program, setting forth (i) the numbers and percentages of the veterans who had service-connected disabilities, (ii) of the veterans having such disabilities, the numbers and percentages who were furnished care for such disabilities, (iii) the ages of the veterans, (iv) taking into account the veterans' past use of Department health-care facilities, an analysis of the extent to which the veterans would have received medical services from the Department outside the

program and the types of services they would have received, and (v) the financial circumstances of the veterans; and

"(E) the types of personnel who furnished services to veterans under the program, including any difficulties in the recruitment or retention of such personnel.

"(2) An assessment by the Secretary of the cost-effectiveness and efficiency of furnishing medical services to veterans through various types of rural clinics (including mobile health-care clinics operated under the pilot program conducted pursuant to section 113 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 38 U.S.C. 1712 note)).

"(3) Any plans for administrative action, and any recommendations for legislation, that the Secretary considers appropriate.

"(g) For the purposes of this section, the term 'Department general health-care facility' has the meaning given such term in section 1712A(i)(2) of this title.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1720D the following new item:

"1720E. Rural health-care clinics: pilot program.".

(b) AUTHORIZATION OF APPROPRIATIONS.—(1) There is authorized to be appropriated for the Department of Veterans Affairs to carry out the rural health-care clinics program provided for in section 1720E of title 38, United States Code (as added by subsection (a)), the following:

(A) For fiscal year 1994, $3,000,000.

(B) For fiscal year 1995, $6,000,000.

(C) For fiscal year 1996, $9,000,000.

(2) Amounts appropriated pursuant to such authorization may not be used for any other purpose.

(3) No funds may be expended to carry out the rural health-care clinics program provided for in such section 1720E unless expressly provided for in an appropriations Act.

SEC. 205. PAYMENT TO STATES OF PER DIEM FOR VETERANS RECEIVING ADULT DAY HEALTH CARE.

(a) PAYMENT OF PER DIEM FOR VETERANS RECEIVING ADULT DAY CARE.—Section 1741 of title 38, United States Code, is amended—

(1) by inserting "(1)" after "(a)";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively; and

(3) by adding at the end the following new paragraph (2):

"(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving adult day health care in a State home, if such veteran is eligible for such care under laws administered by the Secretary.".

(b) ASSISTANCE TO STATES FOR CONSTRUCTION OF ADULT DAY CARE FACILITIES.—(1) Section 8131(3) of title 38, United States Code, is amended by inserting "adult day health," before "or hospital care".

(2) Section 8132 of such title is amended by inserting "adult day health," before "or hospital care".

(3) Section 8135(b) of such title is amended—

(A) in paragraph (2)(C), by inserting "or adult day health care facilities" after "domiciliary beds"; and

(B) in paragraph (3)(A), by inserting "or construction (other than new construction) of adult day health care buildings" before the semicolon.

TITLE III—MISCELLANEOUS

Subtitle A—Education Debt Reduction Program

SEC. 301. SHORT TITLE.

This subtitle may be cited as the "Department of Veterans Affairs Health Professionals Education Debt Reduction Act".

SEC. 302. PROGRAM OF ASSISTANCE IN THE PAYMENT OF EDUCATION DEBTS INCURRED BY CERTAIN VETERANS HEALTH ADMINISTRATION EMPLOYEES.

(a) PROGRAM.—(1) Chapter 76 of title 38, United States Code, is amended by adding at the end the following:

"SUBCHAPTER VI—EDUCATION DEBT REDUCTION PROGRAM

"§ 7661. Authority for program

"(a) The Secretary shall carry out an education debt reduction program under this subchapter. The program shall be known as the Department of Veterans Affairs Education Debt Reduction Program (hereafter in this chapter referred to as the 'Education Debt Reduction Program'). The purpose of the program is to assist personnel serving in health-care positions in the Veterans Health Administration in reducing the amount of debt incurred by such personnel in completing educational programs that qualify such personnel for such service.

"(b)(1) Subject to paragraph (2), assistance under the Education Debt Reduction Program shall be in addition to the assistance available to individuals under the Educational Assistance Program established under this chapter.

"(2) An individual may not receive assistance under both the Education Debt Reduction Program and the Educational Assistance Program for the same period of service in the Department.

"§ 7662. Eligibility; application

"(a) An individual eligible to participate in the Education Debt Reduction Program is any individual (other than a physician or dentist) who—

"(1) serves in a position in the Veterans Health Administration under an appointment under section 7402(b) of this title;

"(2) serves in an occupation, specialty, or geographic area for which the recruitment or retention of an adequate supply of qualified health-care personnel is especially difficult (as determined by the Secretary);

"(3) has pursued or is pursuing, as the case may be—

"(A) a two-year or four-year course of education or training at a qualifying undergraduate institution which course qualified or will qualify, as the case may be, the individual for appointment in a position referred to in paragraph (1); or

"(B) a course of education at a qualifying graduate institution which course qualified or will qualify, as the case may be, the individual for appointment in such a position; and

"(4) owes any amount of principal or interest under a loan or other obligation the proceeds of which were used or are being used, as the case may be, by or on behalf of the individual to pay tuition or other costs incurred by the individual in the pursuit of a course of education or training referred to in paragraph (3).

"(b) Any eligible individual seeking to participate in the Education Debt Reduction Program shall submit an application to the Secretary relating to such participation.

"§ 7663. Agreement

"(a) The Secretary shall enter into an agreement with each individual selected to participate in the Education Debt Reduction Program. The Secretary and the individual shall enter into such an agreement at the beginning of each year for which the individual is selected to so participate.

"(b) An agreement between the Secretary and an individual selected to participate in the Education Debt Reduction Program shall be in writing, shall be signed by the individual, and shall include the following provisions:

"(1) The Secretary's agreement to provide assistance on behalf of the individual under the program upon the completion by the individual of a one-year period of service in a position referred to in section 7662(a) of this title which period begins on the date of the signing of the agreement (or such later date as is jointly agreed upon by the Secretary and the individual).

"(2) The individual's agreement that the Secretary shall pay any assistance provided under the program to the holder (as designated by the individual) of any loan or other obligation of the individual referred to in section 7662(a)(4) of this title in order to reduce or satisfy the unpaid balance (including principal and interest) due on such loan or other obligation.

"(3) The individual's agreement that assistance shall not be paid on behalf of the individual under the program for a year unless and until the individual completes the one-year period of service referred to in paragraph (1).

"(4) The individual's agreement that assistance shall not be paid on behalf of the individual under the program for a year unless the individual maintains (as determined by the Secretary) an acceptable level of performance during the service referred to in paragraph (3).

"§ 7664. Amount of assistance

"(a) Subject to subsection (b), the amount of assistance provided to an individual under the Education Debt Reduction Program for

a year may not exceed $4,000 (adjusted in accordance with section 7631 of this title).

"(b) The total amount of assistance received by an individual under the Education Debt Reduction Program may not exceed $12,000 (as so adjusted).".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following:

"SUBCHAPTER VI—EDUCATION DEBT REDUCTION PROGRAM

"7661. Authority for program.
"7662. Eligibility; application.
"7663. Agreement.
"7664. Amount of assistance.".

(b) CONFORMING AMENDMENTS.—Section 7631 of title 38, United States Code, is amended—

(1) in subsection (a), by striking out "and the maximum Selected Reserve member stipend amount" and inserting in lieu thereof "the maximum Selected Reserve stipend amount, and the education debt reduction amount and limitation"; and

(2) in subsection (b)—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3) the following new paragraph (4):

"(4) The term 'education debt reduction amount and limitation' means the maximum amount of assistance, and the limitation applicable to such assistance, for a person receiving assistance under subchapter VI of this chapter, as specified in section 7663 of this title and as previously adjusted (if at all) in accordance with this subsection.".

(c) REGULATIONS.—The Secretary of Veterans Affairs shall prescribe regulations necessary to carry out the Education Debt Reduction Program established under subchapter VI of chapter 76 of title 38, United States Code (as added by subsection (a)). The Secretary shall prescribe such regulations not later than 90 days after the date of the enactment of this Act.

(d) REPORT.—Section 7632 of title 38, United States Code, is amended—

(1) in the matter above paragraph (1), by inserting "and the Education Debt Reduction Program" before the period at the end;

(2) in paragraph (1)—

(A) by inserting "and the Education Debt Reduction Program" after "Educational Assistance Program";

(B) by striking out "Program and" and inserting in lieu thereof "Program,"; and

(C) by inserting ", and the Education Debt Reduction Program" before "separately";

(3) in paragraph (3), by striking out "the Educational Assistance Program (or predecessor program) has" and inserting in lieu thereof "each of the Educational Assistance Program (or predecessor program) and the Education Debt Reduction Program have";

(4) in paragraph (4)—

(A) by striking out "and per" and inserting in lieu thereof ", per"; and

(B) by inserting ", and per participant in the Education Debt Reduction Program" before the period at the end.

(e) EXEMPTION FROM TAXATION.—Section 7636 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "Notwithstanding"; and

(2) by adding at the end the following:

"(b) Notwithstanding any other law, any payment on behalf of a participant in the Education Debt Reduction Program for the tuition or other costs referred to in section 7662(a)(4) of this title shall be exempt from taxation.".

(f) AUTHORIZATION OF APPROPRIATIONS.—(1) There is authorized to be appropriated for the Department of Veterans Affairs $10,000,000 for each of fiscal years 1994 through 1998 to carry out the Education Debt Reduction Program.

(2) No funds may be used to provide assistance under the program unless expressly provided for in an appropriations Act.

(g) EXEMPTION FROM LIMITATION.—Section 523(b) of the Veterans Health Care Act of 1992 (Public Law 102–585; 38 U.S.C. 7601 note) shall not apply to the Education Debt Reduction Program.

Subtitle B—Other Provisions

SEC. 311. EXTENSION OF AUTHORITY OF ADVISORY COMMITTEE ON EDUCATION.

Section 3692(c) of title 38, United States Code, is amended by striking out "December 31, 1993" and inserting in lieu thereof "December 31, 1997".

SEC. 312. EXTENSION OF AUTHORITY TO MAINTAIN REGIONAL OFFICE IN THE PHILIPPINES.

Section 315(b) of title 38, United States Code, is amended by striking out "March 31, 1994" and inserting in lieu thereof "September 30, 1995".

Amend the title so as to read: "To amend title 38, United States Code, to improve the Department of Veterans Affairs program of sexual trauma services for veterans, to improve certain Department of Veterans Affairs programs for women veterans, to extend the period of entitlement to inpatient care for veterans exposed to Agent Orange or ionizing radiation, to establish a hospice care pilot program, to establish a rural health care clinics program, to authorize the Secretary of Veterans Affairs to provide per diem payments and construction grants to State homes for adult day health care services, to establish an education debt reduction program, and for other purposes.".

INTRODUCTION

On May 26, 1993, the Committee's Chairman, Senator John D. Rockefeller IV, introduced S. 1030, with the cosponsorship of Committee members Dennis DeConcini, Bob Graham, Daniel K. Akaka, Thomas A. Daschle, Ben Nighthorse Campbell, and James M. Jeffords, and Senators Edward M. Kennedy, Kent Conrad, and Patty Murray. Senators Barbara A. Mikulski, Carol Moseley-Braun, and

Barbara Boxer joined later as cosponsors. S. 1030, as introduced, would have extended the Department of Veterans Affairs' authority to furnish care and services for sexual trauma to veterans who experienced such trauma while serving on active duty in the Armed Forces, required VA to assess difficulties veterans face in obtaining service connection for sexual trauma, and expanded VA's Women Veteran Coordinator program.

Earlier, on February 25, 1993, S. 452 was introduced by Senator Kent Conrad with the cosponsorship of Committee members DeConcini, Graham, Akaka, and Daschle, and Senators Byron L. Dorgan, Richard C. Shelby, Carl Levin, J. James Exon, Herb Kohl, Donald W. Riegle, Jr., Larry Pressler, David L. Boren, Jeff Bingaman, Max Baucus, Bob Krueger, David Pryor, Wendell H. Ford, and Alfonse M. D'Amato. Joining later as cosponsors were Senators Paul Simon, Russell D. Feingold, Slade Gorton, Daniel K. Inouye, and J. Robert Kerrey. S. 452 would have established a VA rural health care clinic program.

On April 29, 1993, S. 852 was introduced by Senator Conrad. S. 852 would have authorized VA to make per diem payments to State Veterans Homes for furnishing adult day health care and provide grants to States for renovating or expanding State Homes for the purpose of furnishing adult day health care.

On June 10, 1993, S. 1094 was introduced by Senator Daschle with the cosponsorship of Committee members DeConcini, Akaka, and Campbell, and Senator Kerrey. S. 1094 would have extended the period of entitlement to VA inpatient care for veterans exposed to Agent Orange or radiation for 10 years, from December 31, 1993, to December 31, 2003.

On June 17, 1993, S. 1122 was introduced by Senator Mikulski. S. 1122 would have established a student loan repayment program for certain VA health care professionals.

On June 22, 1993, Chairman Rockefeller introduced S. 1141 with the cosponsorship of Committee Ranking Minority member Frank Murkowski and Committee members Graham and Akaka. Senator Jeffords joined later as a cosponsor. S. 1141 would have established a VA hospice care pilot program.

On June 29, 1993, Chairman Rockefeller introduced S. 1177, which would have extended VA's authority to continue to operate a VA regional office in the Republic of the Philippines and would have extended the Veterans' Advisory Committee on Education.

On June 23, 1993, the Committee held a hearing, chaired by Senator Rockefeller, to receive testimony on S. 1030, S. 452, S. 852, S. 1094, S. 1122, S. 1141, and a draft bill prepared by Senator Rockefeller which would have expanded VA health care services and research relating to women veterans' health care needs. Testimony on these bills was received from the Department of Veterans Affairs Under Secretary for Health, James W. Holsinger, Jr., M.D., and representatives of the American Legion, AMVETS, the American Veterans Committee, the Disabled American Veterans, the Paralyzed Veterans of America, the Veterans of Foreign Wars, and the Vietnam Veterans of America. Written testimony was also submitted by the American Association of Nurse Anesthetists, the American Nurses Association, the National Association of State

Veterans Homes, the National Hospice Organization, and the Nurses Organization of Veterans Affairs.

After carefully reviewing the testimony from the foregoing hearing, the Committee met in open session on July 15, 1993, and voted unanimously to report favorably S. 1030, with an amendment in the nature of a substitute incorporating provisions derived from the aforementioned bills and provisions proposed by Senator Daschle relating to entitlement to VA health care services for veterans who served in the Persian Gulf theater and were exposed during their service to a toxic substance or other environmental hazard.

SUMMARY OF S. 1030 AS REPORTED

S. 1030 as reported (herein referred to as the "Committee bill") consists of three titles summarized below.

TITLE I—WOMEN VETERANS

Title I contains freestanding provisions and amendments to title 38, United States Code, that would:

1. Authorize VA to provide, in addition to counseling for sexual trauma, treatment for physical conditions resulting from that trauma (sections 101(a) and 101(b)).
2. Extend VA's authority to provide sexual trauma care at VA health care facilities for 3 years, through December 31, 1998 (section 101(c)).
3. Extend VA's authority to provide sexual trauma care through contracts with non-VA providers for 4 years, through December 31, 1998 (section 101(c)).
4. Delete provisions in current law that require a veteran to seek sexual trauma care within 2 years of discharge from active duty or, in the case of a veteran discharged before December 31, 1991, by December 31, 1993 (section 101(d)).
5. Delete the 1-year limit in current law on the period of time during which a veteran may receive sexual trauma care (section 101(e)).
6. Require that veterans seeking sexual trauma care have the same priority for that care as veterans who are entitled to VA outpatient services (section 101(f)).
7. Authorize VA to provide sexual trauma care to male veterans (section 101(g)).
8. Require VA (a) not later than 6 months after enactment, to establish and advertise a toll-free phone number to provide confidential crisis intervention and referral services to veterans needing sexual trauma care; and (b) to submit a detailed report to Congress on the toll-free number, not later than 18 months after enactment (section 101(h)).
9. Require the Secretary of Veterans Affairs (a) to submit a report to Congress, not later than June 30, 1994, on the difficulties veterans encounter in obtaining from VA determinations of service-connection for disabilities resulting from sexual trauma experienced while serving on active duty in the Armed Forces; and (b) to submit followup reports to Congress not later than June 30, 1995, and not later than June 30, 1996, on corrective actions taken by VA to address such difficulties (section 102).

10. Require VA's four regional women veterans coordinators to serve in those positions on a full-time basis (section 103(a)).

11. Require VA's regional women veterans coordinators, in addition to carrying out other responsibilities specified in current law, to facilitate communication between women veterans coordinators at VA facilities in their Regions, and the Under Secretary for Health and the Secretary (section 103(b)).

12. Require the Secretary to ensure that women veterans coordinators at VA health care facilities are provided sufficient resources, including clerical support, to carry out their responsibilities (section 103(c)).

13. Ensure that women veterans coordinators have direct access to the directors and chiefs of staffs at the VA health care facilities at which they serve (section 103(c)).

14. Incorporate "women's health services" into the definition of "medical services" provided by VA health care facilities and define those services to include services relating to seven specific types of diseases and conditions: (a) Papanicolaou tests (pap smears); (b) breast examinations and mammography; (c) comprehensive reproductive health care, including pregnancy related care; (d) management of infertility; (e) management and prevention of sexually transmitted diseases; (f) menopause; and (g) physical or psychological conditions resulting from acts of sexual violence (section 104(a)).

15. Authorize the Secretary to enter into contracts to furnish women's health services on an outpatient basis in cases in which a VA health care facility cannot provide the women's health services that a woman veteran entitled to VA outpatient care requires (section 104(b)).

16. Require the Secretary to include the following information in VA's annual report to Congress on health care and research relating to women veterans: (a) The number of inpatient stays and the number of outpatient visits through which women's health services were provided to women veterans during the most recent fiscal year; (b) a description of the VA personnel who provided health care services to women veterans during the most recent fiscal year; (c) a description of any actions the Secretary has taken to recruit and retain personnel to provide health care services to women veterans; (d) an assessment of any difficulties the Secretary experienced in furnishing women's health services and the actions taken by the Secretary to resolve such difficulties; and (e) a description of the Secretary's actions to foster and encourage research relating to women veterans' health care needs (section 104(d)).

17. Expand and clarify the Secretary's responsibility to foster and encourage medical research relating to the health care needs of women veterans by requiring the Secretary (a) to consult with the Director of Nursing Service, the Assistant Chief Medical Director responsible for women veterans programs, the members of the Advisory Committee on Women Veterans, and the members of appropriate VA task forces; (b) to foster and encourage research on eleven specific topics as they relate to women veterans; (c) to encourage personnel affiliated with geriatric research, education, and clinical centers and the National Center for Post-Traumatic Stress Disorder to undertake research relating to women veterans' health

care needs; and (d) to ensure that VA personnel engaged in research relating to women veterans' health care needs are informed about women's health research being undertaken by other VA researchers (section 105(a)).

18. Require that the population study of women veterans mandated under section 110 of Public Law 102-585 (a) be based upon an appropriate sample of women veterans and women serving on active duty in the Armed Forces that constitutes a representative sampling of the ages, ethnic, social and economic backgrounds, the enlisted and officer grades, and the branches of the Armed Forces in which women have served; (b) include an examination of the medical and demographic histories of the women comprising the sample; and (c) include information concerning the number of women in the sample who have used VA health care facilities (section 105(b)).

19. (a) Require that all VA facilities that perform mammography be accredited by a private nonprofit organization, designated by the Secretary of Veterans Affairs; and (b) require the Secretary of VA to designate only a private nonprofit organization that meets standards for accrediting bodies that are no less stringent than those established by the Secretary of Health and Human Services pursuant to the Mammography Quality Standards Act (section 106(a)).

20. Require the Secretary of VA, in consultation with the Secretary of HHS, to issue quality assurance and quality control standards for mammography services furnished in VA facilities that would be no less stringent than the HHS regulations to which other mammography providers will be subject under the Mammography Quality Standards Act of 1992 (section 106(b)).

21. Require the Secretary of VA to issue such regulations not later than 120 days after the Secretary of HHS issues regulations to implement the Mammography Quality Standards Act of 1992 (section 106(b)).

22. Require the Secretary of VA to inspect mammography equipment operated by VA facilities on an annual basis in a manner consistent with requirements contained in the Mammography Quality Standards Act of 1992 concerning annual inspections of mammography equipment by the Secretary of HHS, except that the Secretary of VA would not have the authority to delegate inspection responsibilities to a State agency (section 106(c)).

23. Require VA health care facilities that provide mammography through contracts with non-VA mammography facilities to contract only with facilities that comply with the HHS mammography quality assurance and quality control regulations (section 106(d)).

24. Require the Secretary of VA, not later than 180 days after the Secretary prescribes the mammography quality assurance and quality control regulations, to submit a report to Congress on the implementation of those regulations (section 106(e)).

TITLE II—GENERAL HEALTH CARE SERVICES

Title II contains freestanding provisions and amendments to title 38, United States Code, that would:

1. Extend the period of entitlement to VA inpatient care for veterans exposed to Agent Orange or radiation for 10 years, from December 31, 1993, to December 31, 2003 (section 201).

2. Require the Secretary to furnish hospital and nursing home care to any veteran who may have been exposed to a toxic substance or other environmental hazard while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War on the same basis as care is furnished to a veteran exposed to Agent Orange or radiation (section 202(a)).

3. Require the Secretary to furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed to a Persian Gulf War veteran who may have been exposed to a toxic substance or other environmental hazard, on the same basis as care is furnished to a veteran who has a service-connected disability or a disability rated at 50 percent or more (section 202(b)).

4. (a) Specify that the provisions for entitlement to VA care for such Persian Gulf veterans take effect as of August 2, 1990, and (b) that the Secretary shall reimburse any veteran who paid the United States for VA care before the date of the enactment (section 202(c)).

5. Require VA, during the period beginning on October 1, 1993, and ending on December 31, 1998, to conduct a pilot program in order to (a) assess the feasibility and desirability of furnishing hospice care services to terminally ill veterans; and (b) determine the most efficient and effective means of furnishing such services (section 203).

6. Require VA to furnish hospice care services under the pilot program to any veteran who has a life expectancy of 6 months or less (as certified by a VA physician) and who is (a) entitled to VA hospital care, (b) eligible for and receiving VA hospital or nursing home care, (c) eligible for and receiving care in a community nursing home under a VA contract, or (d) eligible for and receiving care in a State Veterans Home for which VA is making per diem payments to offset the costs of that care (section 203(a)).

7. Specify that the hospice care services that VA must provide to veterans under the pilot program are (a) the services to which Medicare beneficiaries are entitled under the Medicare hospice care benefit; and (b) "personal care services," including care or services relating to dressing, personal hygiene, feeding, and housekeeping (section 203(a)).

8. Require the Secretary to establish hospice care demonstration projects that would provide these services at not fewer than 15 but not more than 30 VA medical centers by one of three means: (a) A hospice operated by a VAMC; (b) a non-VA hospice under contract with a VAMC and pursuant to which the VA facility furnishes any necessary inpatient services; or (c) a non-VA hospice under a contract with a VAMC and pursuant to which a non-VA facility furnishes any necessary inpatient services (section 203(a)).

9. Require that each of the three means for furnishing hospice care services be used at not fewer than five VAMCs (section 203(a)).

10. Require the Secretary to ensure, to the maximum extent feasible, that VAMCs selected to conduct demonstration projects

under the pilot program include facilities that (a) are located in urban areas and rural areas; (b) encompass the full range of affiliations between VAMCs and medical schools; (c) operate and maintain various numbers of beds; and (d) meet any additional criteria or standards that the Secretary may deem relevant or necessary (section 203(a)).

11. (a) Provide that the amount paid by VA to a non-VA hospice under a hospice care services contract generally may not exceed the amount that would be paid to that hospice under the Medicare hospice benefit; and (b) authorize the Secretary to pay an amount in excess of the Medicare reimbursement rate, if the Secretary determines, on a case by case basis, that the Medicare rate would not adequately compensate the hospice for the costs associated with furnishing necessary care to a terminally ill veteran (section 203(a)).

12. Require the Secretary to designate not fewer than 10 VAMCs that would function as a control group and furnish a less comprehensive range of services to terminally ill veterans than the range that VAMCs participating in the pilot program must provide, using one of two means: (a) By VA personnel providing one or more hospice care services to veterans at a VAMC; or (b) by VA personnel monitoring the furnishing of one or more hospice care services to veterans by a non-VA provider (section 203(a)).

13. Require the Secretary to ensure, to the maximum extent practicable, that terminally ill veterans receive information regarding their eligibility (if any) for Medicare's hospice care benefit (section 203(a)).

14. Require the Secretary, not later than September 30, 1994, and on an annual basis thereafter until October 1, 1999, to submit periodic written reports to the House and Senate Committees on Veterans' Affairs about the pilot hospice care program (section 203(a)).

15. Require the Director of VA's Health Services Research and Development Service, not later than August 1, 1997, to submit to the House and Senate Committees on Veterans' Affairs a detailed final report on the pilot program, including (a) an assessment of the feasibility and desirability of furnishing hospice care services to terminally ill veterans; (b) an assessment of the optimal means of furnishing such services; and (c) his/her recommendations, if any, for additional legislation regarding such care (section 203(a)).

16. Clarify that the pilot program would not preclude VA from furnishing hospice care services at VAMCs not participating in the pilot program or the control group (section 203(c)).

17. Authorize the appropriation of funds to cover costs associated with the evaluation of the pilot program in the following amounts: (a) $1.2 million for FY 1994; (b) $2.5 million for FY 1995; (c) $2.3 million for FY 1996; and (d) $1 million for FY 1997 (section 203(d)).

18. Require VA, during the period beginning on October 1, 1993, and ending on September 30, 1996, to conduct a pilot program in order to assess the options for furnishing health care services for veterans living in rural areas of the country.

19. Require VA, as part of this rural health care clinic pilot program, to furnish medical services to veterans through the use of (a) mobile health care clinics equipped, operated, and maintained by

VA personnel; and (b) other types of rural clinics, including part-time stationary clinics operated by VA personnel and part-time stationary clinics operated by non-VA personnel under VA contracts (section 204(a)).

20. Require VA to furnish health care services through the pilot program at locations at least 100 miles from the nearest VA health care facility, or in areas less than 100 miles from the nearest VA health care facility, which the Secretary determines to be appropriate for furnishing health care services through the program (section 204(a)).

21. Extend eligibility to receive health care services through the pilot program to all veterans who are eligible for VA health care services under chapter 17 of title 38 (section 204(a)).

22. Require VA to begin operating at least three rural health care clinics, at least one of which must be a mobile health care clinic, during each of the three fiscal years of the pilot program (section 204(a)).

23. Prohibit VA from operating as part of this pilot program more than one rural health care clinic in any State (section 204(a)).

24. Require the Secretary, not later than 6 months after enactment, to submit a report to Congress on VA's plans for implementing the rural health care clinic pilot program (section 204(a)).

25. Require the Secretary, not later than December 31, 1997, to submit to Congress a detailed report on the pilot program (section 204(a)).

26. (a) Authorize appropriations of $3 million in fiscal year 1994, $6 million in fiscal year 1995, and $9 million in fiscal year 1996 for the rural health care clinic pilot program; and (b) prohibit the expenditure of funds for the program unless expressly appropriated for that purpose (section 204(b)).

27. Authorize VA to provide per diem payments to State Homes for adult day health care services furnished to veterans for whose care State Homes are eligible to receive VA per diem payments (section 205(a)).

28. Authorize VA to provide grants to States for construction, remodeling, or expansion of State Home facilities for purposes of furnishing adult day health care (section 205(b)).

TITLE III—MISCELLANEOUS

Subtitle A—Education Debt Reduction Program

Part A of this title includes freestanding provisions and amendments to title 38, United States Code, that would:

1. Establish an Educational Debt Reduction Program, under which certain VA health care personnel would receive assistance in reducing the amount of debt incurred in completing educational programs that would qualify them for their positions.

2. Make eligible for the program those VA personnel (except physicians and dentists) (a) who have completed or are completing (1) a 2-year or 4-year course of training at an undergraduate institution or (2) a course of training at a graduate institution that qualified or qualifies the individual for the position described in section 7402(b) of Title 38; and (b) who serve in occupations, specialties, or geographic areas with respect to which the Secretary of Veterans

Affairs determines that VA is experiencing great difficulty recruiting and retaining qualified employees (section 302(a)).

3. Require a VA employee, in addition to submitting an application for the program, to enter into an agreement with the Secretary with respect to each year in which the employee seeks assistance under which (a) the Secretary, once the employee has completed the required year of service, would agree to pay the lender holding the employee's student loan the lesser of $4,000 or the principal and interest owed by the employee, and (b) the employee would agree to serve for 1 year in such a position and maintain an acceptable level of job performance while so serving, as a condition of receiving such assistance (section 302(a)).

4. Provide that assistance available to individuals under this program would be in addition to the assistance available under the existing Scholarship and Tuition Reimbursement programs, but prohibit an individual from using years of service required to fulfill obligations under one program to satisfy obligations under the other program (section 302(a)).

5. Provide that the total amount of assistance available to an individual under the Educational Debt Reduction program may not exceed $12,000 (section 302(a)).

6. Require the Secretary (a) to report to Congress on the effectiveness of both the Education Debt Reduction Program and the Health Professional Scholarship Program in retaining VA health care professionals and (b) combine this reporting requirement with the annual report that the Secretary must submit to Congress concerning the Scholarship and Tuition Reimbursement Programs (section 302(d)).

7. Exempt from taxation assistance received by a VA employee through the Educational Debt Reduction Program (section 302(e)).

8. Authorize the appropriation of $10 million to VA for each of fiscal years 1994 through 1998 to carry out the Education Debt Reduction Program (section 302(f)).

Subtitle B—Other Provisions

Part B of this title includes amendments to chapters 3 and 36 of title 38, United States Code, that would:

1. Extend VA's Veterans' Advisory Committee on Education for 4 years, from December 31, 1993, to December 31, 1997 (section 311).

2. Extend VA's authority to maintain a regional office in the Republic of the Philippines for 1½ years, from March 31, 1994, to September 30, 1995 (section 312).

DISCUSSION

TITLE I—WOMEN VETERANS

Sections 101, 102, and 103 of the Committee bill are derived from S. 1030 and sections 104, 105, and 106 are derived from draft legislation prepared by Senator Rockefeller, which the Committee received testimony about at its June 23, 1993, hearing. Except for section 106, all provisions are derived from S. 2973 of the 102nd Congress as reported (S. Rpt. 102–409) by the Committee on Sep-

tember 17, 1992, and passed by the Senate on October 1, 1992, as a Committee amendment to S. 2575 of the 102nd Congress.

Department of Veterans Affairs Sexual Trauma Services Program

Background

Despite concerted efforts over the past two decades to mandate and enforce stronger penalties for offenders, rape and sexual assault remain serious problems in the United States. These problems have not been adequately addressed for women who serve in the Armed Forces. Testimony received by the Committee at hearings in 1992 suggests that many military officials have long tolerated, indeed condoned, flagrant and brutal displays of sexual violence toward military and civilian women and often have been far slower than civilian officials to provide rape victims with the assistance they need to recover from their assaults, and to prosecute their attackers.

Although some have characterized the sexual assaults committed by military personnel at the 1991 Tailhook Association convention as isolated incidents perpetrated by inebriated young persons set free from the rigid constraints of military life, the unacceptable behavior that took place there appears to be merely a manifestation of a problem pervasive throughout the Armed Forces. A 1988 Department of Defense survey indicated that 5 percent of the women who responded had experienced actual or attempted rape or other forms of sexual assault within 12 months prior to participating in the survey. If the respondents were representative of the approximately 222,000 women serving on active duty in 1988, over 11,000 military women would have been victims of sexual violence in that year alone. Indeed, those estimates may well be conservative, given the evidence that many military women do not report rapes or sexual assaults on the belief that doing so could lead to demotion or discharge from active duty.

This phenomenon has profound implications for the Department of Veterans Affairs. Extrapolating the 5 percent figure to the nation's 1.2 million women veterans, at least 60,000 women veterans may have been raped or sexually assaulted while serving on active duty.

Other data suggest the possibility of a dramatically higher incidence of the problem. At the Committee's June 30, 1992, hearing, Jessica Wolfe, Ph.D., of VA's National Center for PTSD division located in Boston, reported the results of a study she conducted with Joan Furey, R.N., of VA's National Center for PTSD division located in Menlo Park, California. The study involved 113 women Vietnam theater veterans who served in Vietnam between 1964 and 1975. Dr. Wolfe reported that 29 percent of these women experienced a sexual encounter accompanied by force or the threat of force while serving on active duty. Susan Angell, Ph.D., M.S.W., Manager of VA's Readjustment Counseling Service (RCS), Pacific Western Regional Office, testified that an informal survey of two VA RCS regions found that out of a total of 173 women who were clients in February 1992, 30 percent reported that they had been sexually assaulted while serving on active duty. Because the military historically has failed to provide victims with assistance when

rapes or assaults occur, women veterans are likely to experience even greater trauma than civilian victims. Experts who testified at the June 30, 1992, hearing advised the Committee that victims who do not receive counseling soon after a rape or assault occurs are far more likely to develop rape-related post-traumatic stress disorder as well as severe eating and sleeping disorders.

At the Committee's June 30 and July 2, 1992, hearings, four women veterans told the Committee about sexual assaults that military officials had failed to document or prosecute. These women also described the profound difficulties they had experienced in obtaining assistance from VA facilities. They indicated that many of the VA health and benefits personnel with whom they came in contact were unwilling or unprepared to assist them in obtaining the treatment/care they needed. Experts in treatment of sexual trauma survivors, representatives of veterans organizations, and VA officials and clinicians supported the veterans' testimony.

Following those hearings, the Committee's then chairman, Senator Alan Cranston, introduced S. 2973 on July 2, 1992. The Committee approved that measure on August 7, 1992, incorporating an amendment that added the women's health provisions from which sections 103, 104, and 105 of the Committee bill are derived. The Senate passed these provisions on October 1, 1992, as part of S. 2575, an omnibus veterans health care measure. Provisions derived from that legislation were subsequently enacted as title I of the Veterans Health Care Act of 1992, Public Law 102–585.

Since that law was enacted, VA officials have been working to carry out its objectives. In May 1993, VA officials held a nationwide video conference to train VA health care personnel in how to respond to sexual assault survivors. More extensive training was provided to key personnel at a conference held in Baltimore, Maryland, in July 1993. Using earmarked funds provided in the FY 1993 VA, HUD, and Independent Agencies Appropriations Act, Vet Centers across the nation are hiring 60 new, part-time, experienced sexual trauma counselors. The FY 93 funds will also be used to establish women's stress disorder teams at four VAMCs, one in each of the four Veterans Health Administration's regions.

Committee bill

The Committee believes that the sexual trauma care provisions enacted in Public Law 102–585 constitute an important first step. However, in the Committee's view, further legislation is required to ensure that VA health professionals can provide appropriate, effective care to veterans who have experienced sexual trauma. Many compromises were made in order to secure enactment of the Public Law 102–585 provisions, some of which may impede VA's ability to meet women veterans' needs. The Committee notes that Secretary Brown also has recommended further legislation in this area and is very pleased that he shares the Committee's commitment to the program's success.

The provisions contained in section 101 of the Committee bill would expand and improve the sexual trauma care program in five major ways.

First, the Committee bill would extend the entire sexual trauma counseling program through 1998 to give VA more time to reach

veterans who need these services. Under current law, VA's authority to carry out this program would expire on December 31, 1995.

The Committee believes that VA needs more time to train and hire sexual trauma counselors, develop referral mechanisms for veterans who need inpatient or contract care, and promote the program. Publicity is especially important because women veterans, who constitute the vast majority of sexual assault survivors, often do not perceive themselves as eligible for VA services. Others may have had bad experiences with VA in the past and may not seek care unless VA makes concerted efforts to inform them about these services.

Second, the bill would require VA to provide care to sexual trauma survivors for physical conditions, stress-related medical problems, and other psychological conditions that a VA health professional determines to result from that sexual trauma. Under current law, VA is limited to furnishing counseling services to a veteran who experienced sexual trauma. In the Committee's view, such a limitation may preclude VA from meeting the needs of a veteran seeking VA care in connection with a sexual trauma. For example, one of the veterans who testified at the Committee's June 30, 1992, hearing, who was sodomized by a superior while on active duty in the Persian Gulf theater in January 1991, testified that she had vomited and ground her teeth virtually every day since her assault. These actions have caused serious damage to her teeth. Yet, because she was not service-connected for these conditions and did not otherwise have a sufficiently high priority for VA dental care, she has experienced great difficulty in obtaining the care she needs. The provision in the Committee bill would ensure that VA meets both the physical and mental health needs of this veteran and other sexual assault survivors.

Third, the bill would repeal the restriction in current law that requires women veterans to seek sexual trauma counseling within two years of discharge from active duty, or by December 31, 1993, in the case of women discharged before December 31, 1991. Experts have advised the Committee that persons who suffer from rape-related PTSD may not display symptoms or seek treatment until many years after the rape occurred. Victims who do not receive assistance soon after the rape occurs are even more likely to exhibit delayed reactions. The restriction in current law prevents VA from helping veterans who may not realize they need counseling until many years after they leave the Armed Forces. Current law imposes no comparable restrictions on veterans who have combat-related PTSD or any other condition.

The Committee bill would also repeal the provision in current law that limits to one year the length of time during which a veteran could receive VA care for sexual trauma. In the Committee's view, this restriction constitutes an undue and inappropriate restriction on VA health care professionals' clinical judgment. As Mary P. Koss, Ph.D., of the University of Arizona Medical School, indicated during the Committee's 1992 hearings, recovery from rape is very difficult because survivors must regain their trust, self-esteem, and sense of control within a society in which women are often accused of provoking the sexual assaults they experience. Recovery is especially difficult for persons who do not seek treat-

ment until many years after a rape has occurred. For these persons, one year of therapy may be insufficient. Unless such persons receive further assistance, they may never be able to overcome rape-related PTSD and other serious conditions with which they are afflicted. Current law imposes no comparable restrictions on the duration of treatment regimes that VA health care professionals can administer to veterans who have combat-related PTSD.

The Committee bill would also authorize VA to provide sexual trauma counseling to male veterans. Under current law, only women veterans are eligible for this service.

Finally, the Committee bill would increase the priority for VA outpatient care accorded to veterans who seek care for sexual trauma. Under current law, these veterans have the same priority for care as a veteran who has a service-connected disability rated at 30 percent or below and who is seeking care for a non-service-connected disability or who is being examined to determine the existence or severity of a service-connected disability. In these times of tight budget constraints, the Committee is concerned that this priority level may not be sufficiently high to ensure that veterans seeking care in connection with sexual trauma will receive the care they need to cope with the effects of their experiences. Moreover, many of these veterans have chronic mental and physical disabilities which could be service connected but which often are not rated as such because their experiences are not documented in their military records. Thus, the Committee bill would increase the priority accorded to these veterans for sexual trauma care to that accorded to any veteran seeking care for a service-connected disability or for the treatment of any disability of a veteran who has a service-connected disability rated 50 percent or above.

Reports Relating to Determinations of Service Connection for Sexual Trauma

Background

Veterans who have been victims of sexual violence that occurred during active-duty service may be eligible for VA compensation if they are found to have a physical or psychological disability stemming from sexual trauma. Disabilities common among sexual assault survivors include PTSD, depression, anxiety, and sleeping and eating disorders. The procedure for filing a disability compensation claim for the aftereffects of sexual trauma is the same as that which a veteran must follow for any other claim. Determinations are based on various sources of information, such as service and post-service medical records, affidavits from individuals who served with the veterans, and other forms of evidence that document a veteran's experiences on active duty.

A leading expert on rape, Dean Kilpatrick, Ph.D., Professor of Clinical Psychology and Director of the Crime Victims Research and Treatment Center at the Medical University of South Carolina, testified at the June 30, 1992, hearing that the vast majority of sexual assault victims do not report these incidents to police or other authorities nor do they seek medical care. Data from the 1992 National Women's Study, a longitudinal survey directed by Dr. Kilpatrick, suggest that only 16 percent of all forcible rapes are

reported. Military personnel may be even less likely to report sexual assaults due to lack of support from a predominantly male command and fear of reprisals from perpetrators.

Because military personnel very often do not report rapes or assaults, there is frequently no recorded evidence in their military records that the incidents took place. This creates a tremendous hurdle for veterans who attempt to obtain VA health care disability compensation or rehabilitative services for the aftereffects of sexual trauma that occurred while on active duty service.

Committee bill

The Committee is extremely concerned that veterans may not be receiving health care services, compensation, and other assistance to which they may be entitled for disabilities that resulted from sexual trauma experienced while on active duty. However, at this time, the Committee does not have sufficient information to assess the scope and severity of difficulties these veterans face in obtaining from VA determinations of service connection for sexual trauma. The Committee believes that if specific difficulties encountered by veterans who experienced sexual trauma are identified, appropriate administrative and legislative action can then be taken to resolve these problems.

In order to improve the information available to VA and the Committee, section 102 of the Committee bill would require the Secretary, not later than June 30, 1994, to complete a study on the difficulties veterans encounter in obtaining VA determination that disabilities resulting from sexual trauma are service connected and the extent to which VA personnel fail to make such determinations. Section 102 would also require the Secretary, not later than June 30 of 1995 and 1996, to issue followup reports on actions taken to correct these problems. The Committee expects the Secretary to examine this matter thoroughly, recommend legislative action, if appropriate, and modify regulations and management practices that may prevent veterans from receiving compensation for their disabilities.

Coordinators of Women's Services

Background

Each VAMC has a women veterans coordinator who is responsible for ensuring that women veterans' health care needs are addressed promptly and appropriately. Women veterans coordinators are intended to form a critical link between women veterans and VA health professionals who provide the specific services these veterans need. They may play an especially important role in sexual trauma care, because many rape and sexual assault survivors initially seek care for physical conditions triggered by their assaults.

In June and July 1992, members of the Committee staff called over 20 VAMCs and asked the operator to connect them with the women veterans coordinator. Not one of these calls went through without a problem. The Committee staff members reported that during these calls, they were frequently given inaccurate information, put on hold for extended periods of time, or transferred a number of times to incorrect telephone extensions. Such delays and

lack of attention may have very serious consequences when a woman veteran calls for assistance. When calling, the Committee staff knew and gave the VA title of the position and, knowing that such a position existed—at least nominally—at each VAMC, were able to persist in their demands to be connected with the women veterans coordinator. A woman veteran with a health problem who calls a VAMC for assistance faces a much greater obstacle to contacting a women veterans coordinator and obtaining the assistance she needs.

Committee bill

Section 103 of the Committee bill contains three provisions that are designed to improve the women veterans coordinator program. First, the Committee bill would require each of VA's women veterans coordinators located in the four Veterans Health Administration regional offices to serve on a full-time basis. The Committee believes that full-time regional women veterans coordinators are needed to ensure that coordinators at VAMCs receive appropriate guidance and support. At the June 23, 1993, hearing, VA's Under Secretary for Health, Dr. James Holsinger, Jr., expressed support for the Committee's position and noted that VA expected to have full-time coordinators in place in each of the Veterans Health Administration's four regions. Section 103 would also require the regional coordinators, in addition to carrying out other responsibilities mandated under Public Law 102–585, to facilitate communication between women veterans coordinators at VAMCs and VA officials.

In order to ensure that women veterans coordinators can respond effectively to women veterans' needs, section 103 would also require VA to provide coordinators with adequate clerical and communications support and ensure that coordinators have direct access to the directors and chiefs of staff at the VAMCs at which they serve. Clerical and communications support is particularly critical at VAMCs in which women veterans coordinators do not serve on a full-time basis. Without such assistance, these coordinators can have great difficulty keeping track of women patients and promoting services of benefit to women. The Committee expects that the four regional women veterans coordinators would have primary responsibility for ensuring that individual VAMCs follow these requirements.

Women's Health Services

Background

The Committee's July 1, 1992, hearing and a January 1992 GAO report both revealed serious deficiencies in law and policy governing VA health care services for women veterans. Although GAO had identified many of the same deficiencies 10 years earlier in its initial report on this topic, GAO found that VA as a whole, despite the diligent efforts of many dedicated individuals, had made little progress toward improving services for women veterans. The Committee believes that the provisions enacted last year in Public Law 102-585 made significant steps in the right direction to address these problems, but that more can and must be done in this area.

The latest documentation of VA's performance in meeting the health care needs of women veterans is provided in a VA Inspector General's report assessing the availability of treatment facilities and programs for women veterans. The report, released on June 17, 1993, revealed that VA medical centers did not provide a consistent level of service to women veterans. Specifically, the IG found that female patients in VA medical centers could not be assured of privacy, full information about the services to which they were entitled, and access to specialized medical equipment, such as mammography machines.

The Committee believes that the expansion and improvement of VA health services for women veterans is vital to the future of the VA health care system. The Committee expects that the President, as part of his national health care reform plan, is likely to propose that VA compete directly with non-VA providers for patients. In addition, the President's plan likely will provide veterans entitled to VA care, many of whom are presently uninsured, a wider range of health care choices. Under this scenario, VA would have to furnish a wide range of health care services, including comprehensive reproductive services, in order to be included as an option under health care reform. To compete on a level playing field with the private sector, many changes will be required.

Committee bill

Section 104 of the Committee bill would incorporate "women's health services" into the title 38 definition of "medical services" provided by VA health care facilities and define those services to include services relating to seven specific matters: (a) Papanicolaou tests (pap smears); (b) breast examinations and mammography; (c) comprehensive reproductive health care, including pregnancy related care; (d) management of infertility; (e) management and prevention of sexually transmitted diseases; (f) menopause; and (g) physical or psychological conditions resulting from acts of sexual violence. Under current law, VA has no authority to furnish these specific services except in connection with the treatment of a disability. According to VA's General Counsel's interpretation of disability, VA can only furnish reproductive health services such as prenatal and obstetrical care in cases in which a veteran's pregnancy is complicated.

Under the Committee bill, VA would be authorized to enter into contracts to furnish women's health care services on an outpatient basis in cases in which a VA health care facility, because of geographical inaccessibility or a lack of capacity, cannot provide the women's health care services that a woman veteran requires.

The Committee bill also would require the Secretary to include the following information in VA's annual report to Congress on health care and research relating to women veterans: (a) The number of inpatient stays and the number of outpatient visits through which women's health care services were provided to women veterans during the most recent fiscal year; (b) a description of the VA personnel who provided health care services to women veterans during the most recent fiscal year; (c) a description of any actions the Secretary has taken to recruit and retain personnel to provide health care services to women veterans; (d) an assessment of any

difficulties the Secretary experienced in furnishing women's health care services and the actions taken by the Secretary to resolve such difficulties; and (e) a description of the Secretary's actions to foster and encourage research relating to women veterans' health care needs.

Expansion of Research Relating to Women Veterans

Background

VA leads the nation in clinical, rehabilitation, and health services research, but for far too long women have been under-represented in its research studies. Although VA, as set forth in VHA Circular 10–91–057, now requires all applicants for clinical research support to consider inclusion of women and minorities in their research proposals, there is little evidence of a concerted effort on the part of VA officials to enforce this policy. The Committee recognizes that many VAMCs do not treat sufficient numbers of women veterans to facilitate their inclusion in single-site research projects. However, the Committee also believes that VA's cooperative studies program, which coordinates numerous multi-site studies, could be used to help overcome this obstacle.

Moreover, VA has not funded research on female-specific conditions in proportion to the percentage of veterans who are women, nor has VA adequately supported research to determine whether certain diseases and conditions are more common among women veterans than other women. Less than $2 million of the $232 million appropriated for VA health care research in fiscal year 1993 went directly to issues which concern women veterans, despite the fact that women constitute over four percent of the total veteran population. The Committee believes that this level of research funding does not constitute sufficient funding, especially in light of the increasing number of women veterans who are seeking care at VA facilities. Without additional funding, VA may find it difficult to recruit and retain health professionals who have expertise in these areas.

Committee bill

Section 105 of the Committee bill contains provisions that would amend provisions enacted in Public Law 102–585 in order to further improve and expand VA research relating to women veterans' health care needs. These provisions would provide more specific direction to the Secretary with regard to VA's responsibility to foster and encourage medical research relating to the health care needs of women veterans. The Secretary would be required to consult with particular VA officials and members of appropriate advisory bodies and task forces in formulating plans to promote VA research concerning eight specific types of diseases and conditions as they relate to women. These diseases and conditions include female-specific conditions, such as menopause and osteoporosis, as well as conditions, such as substance abuse, that may manifest themselves differently in women than in men. In addition, the Secretary would be required to inform VA personnel engaged in research relating to women veterans' health care needs about women's health research being undertaken by other VA researchers.

Section 105 would also provide additional guidance to the Secretary concerning the population study of women veterans that the Secretary is required to carry out pursuant to section 110 of Public Law 102–585. In developing that study, the Committee bill would require the Secretary to draw an appropriate sample of women veterans and women serving on active duty in the Armed Forces that would constitute a representative sampling of the ages, ethnic, social and economic backgrounds, the enlisted and officer grades, and the branches of the Armed Forces in which women have served. The Secretary would also be required to incorporate into the study an examination of the medical and demographic histories of the women comprising the sample and information concerning the number of women veterans in the sample who have used VA health care facilities.

Mammography Quality Standards

Background

Finally, title I of the Committee bill would attempt to ensure that women veterans will receive safe and accurate mammograms from or through VA. At present, under the Mammography Quality Standards Act of 1992, Public Law 102–539, all health care facilities—hospitals, outpatient departments, clinics, physicians' offices, or mobile units—are required to be certified by the Secretary of HHS as meeting specified standards for mammography in equipment, personnel, and quality assurance. That law, however, does not apply to VA facilities that operate their own mammography equipment. Further background information about mammography quality assurance may be found in the Committee on Labor and Human Resources' report on S. 1777 of the 102nd Congress (S. Rpt. 102–448), the legislation from which the Mammography Quality Standards Act of 1992 was derived.

It is the Committee's view that women veterans who use VA facilities should have the same assurances as other women that their mammography tests will be performed properly and yield reliable information. The Secretary of Veterans' Affairs agrees. In a letter to Chairman Rockefeller dated July 12, 1993, Secretary Jesse Brown wrote, "It is my intent that VA will comply with standards equal to those set forth in the Mammography Quality Standards of 1992 for all mammography done within VA facilities and require that all contracts and sharing agreements for mammography include a provision for compliance."

Committee bill

Section 106 of the Committee bill would achieve the goal of giving women veterans safe and accurate mammograms by requiring the Secretary to promulgate quality assurance and quality control regulations for VA facilities that furnish mammography that are no less stringent than the Department of Health and Human Services regulations to which other mammography providers are subject under the Mammography Quality Standards Act of 1992. VA facilities that contract with non-VA facilities would be required to contract only with facilities that comply with that Act. The Secretary of Veterans Affairs would be required to issue these regulations not

later than 120 days after the Secretary of HHS issues regulations to implement that Act. In addition, the VA Secretary would be required, not later than 180 days after prescribing the mammography quality assurance and quality control regulations, to submit a report to the House and Senate Committees on Veterans' Affairs on the implementation of those regulations.

Section 106 would also require that all VA facilities that furnish mammography be accredited by a private nonprofit organization designated by the Secretary of VA. The Secretary would be permitted to designate only an accrediting body that meets the standards for accrediting bodies issued by the Secretary of HHS for purposes of accrediting mammography facilities subject to Public Law 102–539. The American College of Radiology (ACR) currently administers a voluntary accreditation program for mammography providers and, at the present time, is the only accrediting body that meets those requirements. Thus, the Committee anticipates, if section 106 is enacted, that ACR would serve as VA's accrediting body.

Finally, the Secretary would be required to ensure that mammography equipment operated by VA facilities is inspected on an annual basis in a manner consistent with requirements contained in the Mammography Quality Standards Act of 1992 concerning annual inspections of mammography equipment by the Secretary of Health and Human Services, except that the Secretary of Veterans Affairs would not have the authority to delegate inspection responsibilities to a State agency. The Committee expects VA to correct any deficiencies uncovered as a result of these inspections.

TITLE II—GENERAL HEALTH CARE SERVICES

Extension of Period of Eligibility for Medical Care for Exposure to Dioxin or Ionizing Radiation

Section 201 of the Committee bill, which is derived from S. 1094, would extend through December 31, 2003, eligibility for priority medical care for certain veterans exposed to ionizing radiation or Agent Orange or other herbicides.

Background

In 1981, Public Law 97–72 expanded eligibility for VA health care services to veterans exposed to Agent Orange or other herbicides in Vietnam or exposed to radiation during participation in the nuclear weapons testing program or the American occupation of Hiroshima or Nagasaki, Japan.

The practical effect of this provision was to provide health care eligibility to these veterans for treatment of any disability, even if there is insufficient medical or scientific evidence to conclude that the disability may be associated with exposure to radiation or herbicides, unless VA can demonstrate that the disease resulted from a cause other than exposure.

Congress was satisfied that, as to some disabilities, such as traumatic injuries and infectious diseases, valid medical judgments can be made that a particular disability is the direct result of a specific cause other than the exposure. However, in recognition of the scientific uncertainties regarding the levels of exposure and the potential adverse human health effects of exposure to herbicides or radi-

ation, the burden is placed on VA to establish that a disability was not caused by the exposure, rather than on the veteran to show that the disability was caused by the exposure.

The health care services provided under this provision include inpatient VA hospital care and outpatient or ambulatory care provided on a pre- or post-hospitalization basis or to obviate the need for hospitalization. In addition to the direct benefit to the veteran, this provision also embodied Congress' commitment to providing immediate assistance to veterans suffering health problems that eventually might prove related to their service, while efforts continued to determine whether there is a relationship.

In enacting this provision, Congress acknowledged that the information needed ultimately to resolve questions of service connection was not, and might not ever be, available in certain cases.

The authority for VA to provide health care under Public Law 97–72 was to expire one year after VA's first report to Congress on an epidemiological study of veterans exposed to dioxin, which Congress previously had mandated under Public Law 96–151. The authority to provide medical care to veterans exposed to radiation under this law was to expire at the same time. The temporary provision was to provide interim relief to veterans until VA had the results of ongoing scientific research concerning the health effects of radiation and herbicide exposure.

The Secretary was required to submit the first report on the dioxin study no later than 24 months after approval of the study protocol by the Director of the Office of Technology Assessment, which occurred on February 14, 1984. Thus, VA was supposed to provide the first report on the study by February 14, 1986, and the health care eligibility thus would have expired on February 14, 1987. The study concerning dioxin exposure and a study relating to radiation exposure mandated by Public Law 98–160 were the primary studies intended to yield the information necessary to make decisions about permanent eligibility for VA benefits based on herbicide or radiation exposure, including eligibility for health care. When it became clear that these two studies would not be sufficiently advanced by 1987, Congress passed legislation in 1985, Public Law 99–166, to extend the health care eligibility until September 30, 1989.

In 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99–272, amended the law to direct, rather than merely permit, VA to furnish hospital care to veterans exposed to radiation and herbicides. Access to outpatient care was not changed.

In 1988, Congress recognized that information from various studies relating to the effects of exposure to radiation and herbicides still was forthcoming and extended the health care eligibility provisions until December 31, 1990, as part of Public Law 100–687.

Also in 1988, Congress enacted Public Law 100–321 to provide a presumption of service connection based on radiation exposure for 13 types of cancer. In 1992, Congress added two additional diseases to the list of presumptions of service connection (see section 2 of Public Law 102–578). Veterans with any of these presumptively service-connected cancers are eligible for priority VA health care for those conditions by virtue of their status as service-disabled vet-

erans. For other veterans who participated in radiation-risk activities and have conditions possibly related to the exposure but not presumptively service-connected by law (see section 1112(c) of title 38, United States Code), the health care entitlement originally provided by Public Law 97–72 continues to serve as the basis for eligibility to health care.

The Committee notes that the Medical Follow-up Agency (MFUA) of the National Academy of Sciences, under contract with VA, is conducting a followup mortality study of veterans who were exposed to radiation at the Operation Crossroads nuclear test in the Pacific Ocean in 1946. This study was mandated by Public Law 98–160. There have been a number of delays in this study due to difficulties encountered by MFUA, but the Committee understands that final negotiations are underway between VA and MFUA for completion of the study and that the target date for completion is by the end of 1995.

The National Academy of Sciences also is correcting a 1985 study of five nuclear detonations, entitled "Mortality of Nuclear Weapons Test Participants." The General Accounting Office and the Office of Technology Assessment confirmed MFUA's concerns in 1992 that the Defense Department provided flawed data to MFUA for the study. (See U.S. General Accounting Office, "Nuclear Health and Safety: Mortality Study of Atmospheric Nuclear Test Participants Is Flawed" GAO/RCED–92–182 (August 1992) and Office of Technology Assessment, "A Discussion of Questions About the 1985 NAS Report 'Mortality of Nuclear Weapons Test Participants'" (August 1992).) This study should be completed in three or four years.

When these two studies are completed, the Committee and Congress will have significant additional information to use as the basis for deciding whether to add to the list of diseases for which service connection is presumed under Public Laws 100–321 and 102–578, codified in section 1112(c) of title 38, United States Code, and whether permanent priority access to health care for radiation-exposed veterans is necessary and appropriate.

With respect to herbicide exposure, VA in 1990 established by regulation a presumption of service connection for non-Hodgkin's lymphoma in veterans who served in Vietnam. In 1991, VA adopted a regulation to presume service connection for soft-tissue sarcoma in veterans exposed to Agent Orange. These veterans therefore became eligible for VA health care for these cancers based on the diseases' status as service-connected conditions. VA regulations already presumed service connection for chloracne based on Agent Orange exposure if the condition appeared within three months of exposure.

The Agent Orange Act of 1991, Public Law 102–4, extended health care eligibility based on exposure to herbicides and radiation through December 31, 1993. The law also codified presumptions of service connection for non-Hodgkin's lymphoma and expanded and codified the presumption for chloracne and soft-tissue sarcoma. The Act was derived from S. 238 and title II of S. 1 in the 102d Congress; title I, part C of S. 2100 (S. Rept. 101–379, pp. 104–106), S. 1153 (S. Rept. 101–82), and title VIII of S. 13 as passed (see Congressional Record S12515–S12519 (October 3, 1989)) in the 101st Congress; and various earlier Senate bills.

Public Law 102–4 also required VA to contract with the National Academy of Sciences for a review of the scientific literature on the health effects of exposure to Agent Orange and other herbicides used in Vietnam. NAS conducted an 18-month review and reported to the Senate and House Committees on Veterans' Affairs and to VA on this initial review on July 27, 1993. The NAS committee that carried out the review found sufficient evidence to conclude that there is a positive association between exposure to herbicides and five conditions. Current law already reflects presumptions of service connection for three of those conditions: soft-tissue sarcoma, non-Hodgkin's lymphoma, and chloracne. Vietnam veterans with these three service-connected diseases thus currently are eligible for priority health care. Based on the NAS findings, VA decided on July 27, 1993, to establish by regulation presumptions of service connection for the two other conditions: Hodgkin's disease and porphyria cutanea tarda. When VA publishes final regulations for these two additional conditions, Vietnam veterans with these conditions will be eligible for VA health care based on the service-connected status of their disabilities.

The NAS committee also found limited, but suggestive, evidence of an association between herbicide exposure and several other conditions.

For another large group of conditions, the NAS committee concluded there is insufficient evidence at this time to determine whether an association exists. The committee concluded that further study of the health effects in Vietnam veterans of exposure to herbicides can and should be done.

Public Law 102–4 required VA to contract with NAS for followup reports to be issued at least every two years for ten years following issuance of the first report.

In testimony before the Committee on Veterans' Affairs at a June 23, 1993, hearing, several veterans service organizations generally supported extension of this health care authority. VA supported extending this authority for two years.

Committee bill

Section 201 of the Committee bill would extend, from December 31, 1993, to December 31, 2003, priority VA health care eligibility for treatment of conditions possibly related to exposure to herbicides or radiation. Under current law, health care eligibility for these veterans would end after December 31, 1993.

The Committee believes that sufficient questions still exist regarding the effects of human exposure to Agent Orange and ionizing radiation to warrant continuation of priority health care eligibility under section 1710 of title 38, United States Code. In light of the NAS committee's findings concerning the current state of the science on the health effects of exposure to Agent Orange and other herbicides and the potential for further study, as well as the requirement in Public Law 102–4 for followup reviews by NAS, the Committee believes that the authority for health care based on Agent Orange exposure should be extended for 10 years.

With respect to veterans exposed to ionizing radiation, the ongoing studies by NAS and others provide grounds for extending health care eligibility for these veterans for 10 years.

Cost: CBO indicated that on the basis of current information available, they were unable to estimate the costs entailed in enactment of section 201.

Authority To Provide Priority Health Care to Veterans of the Persian Gulf War

Section 202, which would establish access to VA health care for veterans of the Persian Gulf War, is based on an amendment proposed by Committee members Tom Daschle and James Jeffords at the July 1, 1993, markup of S. 1030.

Background

Since their service in the Persian Gulf theater of operations, many members of the U.S. Armed Forces have experienced serious, unexplained health problems that many suspect are related to their in-theater service before, during, or after the war. In recent months, public attention has been focused on the "mysterious illnesses" experienced by Persian Gulf veterans. Returning veterans and servicemembers have reported lingering symptoms, such as joint pain, chronic fatigue, hair loss, bleeding gums, and skin rashes. A small number of veterans also have experienced specific health problems that clearly are related to this service, such as leishmaniasis, which results from infection by a known tropical parasite.

Some servicemembers have related these health problems to the effects of burning oil from wells in Kuwait set afire by enemy troops. However, no scientific link has been established yet between the unexplained symptoms and the oil fires. In fact, a number of environmental scientists have suggested that the oil fires burned so hot that they emitted only soot and other particulate matter, with practically no detectible levels of the volatile petrochemicals that might cause health problems. Attention also has been focused on the potential health effects of other chemical substances used during military operations in the Persian Gulf.

One primary underlying concern with respect to the health problems of Persian Gulf War veterans is the importance of avoiding a situation like the one surrounding the issue of Vietnam veterans' exposure to Agent Orange. One of the major difficulties in trying to resolve whether certain diseases are related to Agent Orange exposure in Vietnam has been the effort to document who was exposed to the herbicide, using old and inadequate information about troop locations and other circumstances of veterans' service in Vietnam.

In 1991, the Committee worked with the Armed Services Committee to draft an amendment to the National Defense Authorization Act for Fiscal Years 1992 and 1993 (Public Law 102–190) that created a Department of Defense (DoD) registry of all servicemembers who were exposed to the fumes of burning oil during service in the Persian Gulf. The purpose of the registry is to preserve and analyze information about these troops that could prove vital in assessing the health impact of the oil fires and eligibility for veterans benefits and services.

However, with the appearance of the unexplained and unidentified medical problems experienced by Persian Gulf veterans, Con-

gress recognized that the DoD registry, limited to servicemembers exposed to fumes, was insufficient. Therefore, title VII of the Veterans' Health Care Act of 1992 (Public Law 102–585) required creation of a VA health status registry of Persian Gulf War veterans, authorized health examinations of these veterans, and required the expansion of the DoD registry to include information about anyone who served in the Persian Gulf War theater of operations, regardless of whether they had been exposed to fumes from the oil fires.

The VA registry and health examinations are meant to complement the information in the DoD registry, and to serve as an "early warning system" and scientific resource for studying possible service-connected health problems in Persian Gulf veterans. The VA examinations and registry are intended to give VA an opportunity to observe and monitor the health of these veterans, helping researchers to design and plan valid, long-term scientific studies of reported medical problems without requiring immediate, possibly incorrect, conclusions about specific conditions or mandating any particular studies. The expanded DoD registry will include information about troop locations and atmospheric and environmental measurements for specific locations and times.

Public Law 102–585 also directed the Office of Technology Assessment (OTA), an agency of the Congress, to evaluate the potential scientific usefulness of both the new VA registry and the existing DoD registry. OTA will provide Congress with its first report on the effectiveness of the VA registry in September 1993.

In addition, Public Law 102–585 required VA and DoD to contract with the National Academy of Sciences' Medical Follow-up Agency (MFUA) to review the existing scientific, medical, and other information on the health consequences of military service in the Persian Gulf theater of operations. Under this provision, MFUA also will assess the effectiveness of efforts by VA and DoD to collect and maintain information potentially useful for assessing these health consequences. Finally, MFUA will evaluate and recommend whether there is a scientific basis for VA and DoD to undertake an epidemiological study or studies and, if so, what types of studies would be appropriate.

Many veterans who became ill during or after serving in the Persian Gulf have sought medical treatment at VA facilities. Their access to VA health care has not been consistent across the VA system. The Committee notes with approval VA's recent efforts to begin answering some of the questions surrounding the health problems of these veterans and to provide adequate medical treatment to them. VA's actions are a good starting point, but an overall policy is necessary to ensure that Persian Gulf veterans receive adequate and appropriate health care from VA.

Under current law, VA does not have the authority to provide health care on a priority basis for those Persian Gulf veterans who cannot yet prove that their illnesses are service-connected, unless the veteran happens to qualify on the basis of income. For those who do not have either a service-connected disability or income below a specified level, VA may furnish care on a discretionary basis, that is, only if space and resources are available after caring for mandatory category veterans and if the veteran pays a

copayment. Under current budget constraints, this could mean that many Persian Gulf veterans would be shut out of VA health care.

The Committee is concerned that if Persian Gulf veterans have to wait for care until resources became available, their medical problems may worsen or become permanent disabilities. The Committee also recognizes that scientific evidence some day could link environmental hazards in the Persian Gulf theater of operations with various illnesses. The Committee does not believe, however, that veterans should have to wait until that time to receive VA health care for illnesses possibly related to service in the Gulf.

Committee bill

Section 202 of the Committee bill would provide specific additional authority to the Secretary, through September 30, 2003, to provide priority health care for veterans of the Persian Gulf War.

The Committee bill would require the Secretary to furnish hospital care to any veteran who may have been exposed to a toxic substance or other environmental hazard while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War, on the same basis as care is furnished to a veteran exposed to Agent Orange or radiation. Thus, VA would be required to furnish hospital care on a mandatory basis for the treatment of any disability that VA cannot demonstrate resulted from a cause other than the veteran's exposure to a toxic substance or environmental hazard during the veteran's service in the Persian Gulf. Such substance abuse or hazard would include petrochemicals, pharmaceuticals or other chemical agents administered by DoD, indigenous diseases, pesticides, and inhalation or ingestion of depleted uranium or wounds caused by depleted uranium.

In addition, because of the nature of the illnesses reported by Persian Gulf veterans—many of which can and should be treated on an outpatient basis—the Committee is convinced that it is especially important that these veterans also have access to VA outpatient care on a priority basis.

Under the Committee bill, VA would be required to furnish on an outpatient basis such medical services as the Secretary determines are needed to such a Persian Gulf veteran for the treatment of any disability that cannot be associated with a cause other than exposure to a toxic substance or environmental hazard, on the same basis and with the same priority as VA currently furnishes outpatient care to a veteran who is receiving care for a service-connected disability or for a non-service-connected disability if the veteran is rated at 50 percent or more disabled.

The Committee bill would specify that the entitlement to VA care for such Persian Gulf veterans take effect as of August 2, 1990, and that the Secretary shall reimburse retroactively qualified veterans who made any payments to the United States for VA care provided after this date.

Cost: According to CBO, the enactment of section 202 would entail costs of less than $500,000 in budget authority and less than $500,000 in outlays in FY 1994.

Programs for Furnishing Hospice Care to Veterans

Section 203 of the Committee bill is derived from S. 1141, which in turn was derived from S. 1358 of the 102nd Congress which the Committee reported on September 24, 1991, and the Senate passed on October 16, 1991.

Background

At the Committee's June 23, 1993, hearing, Ms. June Willenz, Executive Director of the American Veterans Committee, referred to the growing aging population within VA and said, "The VA needs to learn and develop the best and most cost-effective methods of providing treatment for these specially targeted groups of veterans most likely to use VA in the future." The Committee agrees with this sentiment and notes that such methods encompass a wide variety of community-based, noninstitutional services, including hospice care, which provides a compassionate alternative to customary curative care for terminally ill persons.

The Committee's analysis of testimony from hearings held on May 19, 1993, and June 23, 1993, as well as testimony from a June 12, 1991, hearing, confirms that the provision of hospice care is a valuable service which VA has been slow to develop.

Since 1991, VA has moved ahead cautiously to establish programs which achieve the goals of hospice care. On April 30, 1992, VA issued a directive that required all VA medical centers (VAMC) to implement hospice programs. However, that directive provided only vague guidelines regarding the manner in which VAMCs should provide hospice care, and as a result, significant variations now exist in the manner in which hospice care is provided at VAMCs.

At present, all VAMCs are now reported to have hospice consultation teams, consisting of at least a physician, nurse, social worker, and chaplain, and 40 out of 171 VAMCs have inpatient hospice units, freestanding buildings or separate units where a home like atmosphere is created. Other VAMCs provide pain management and other services to terminally ill veterans in units in which hospice rooms are adjacent to rooms in which other patients are administered curative care. Still other VAMCs only provide some hospice services such as caregiver counseling and pain management.

Unfortunately, many VAMCs hospice efforts offer only an assessment of a terminally ill veteran's needs and referral to a non-VA hospice. While such referrals may benefit some veterans, they are of little value to the many veterans who are not entitled to Medicare or Medicaid or lack health insurance coverage for hospice care. Because VA has no authority under current law to contract with non-VA hospices, these veterans are left with the difficult choice of foregoing hospice care or using their own resources to pay for that care.

The Committee is convinced that VA should provide hospice care but remains uncertain as to the best way to provide such care. Some assert that the only bona fide form of hospice care is through a program in which palliative care (noncurative care focusing on alleviating pain and other symptoms) and support services to meet

the psychological, social, and spiritual needs of patients and their families are available in both home and inpatient settings. Others believe that equally effective care can be furnished by integrating hospice concepts into customary care. Similarly, there is considerable disagreement as to whether veterans who wish to receive hospice care are best served by VA hospice programs or through contracts with non-VA providers.

To this point, VA has not undertaken sufficient research to answer to determine with any degree of certainty the most appropriate way in which to furnish hospice care. Therefore, the Committee believes that a study of the ways in which hospice care can successfully be furnished to veterans is warranted.

Section 203 is consistent with the goals of health care reform, which is to determine cost effective models of care. Given the growing numbers of VA patients who are elderly or have fatal diseases who could benefit from hospice care, demand for VA hospice care is likely to increase regardless of the particulars of VA and national health care reform—the details of which are still pending at this time. Research related to the provision of hospice care is critical not only to VA health care professionals, many of whose patients cannot rely on friends and family to provide all of the care they require, but also to other health care providers who will soon have to accommodate a great increase in the number of aging patients comparable to that which VA is presently providing care.

Committee bill

Section 203 of the Committee bill would require VA to conduct a 5 year pilot program, from October 1993 to December 1998, to evaluate the best way to provide hospice care. In developing the legislation, the Committee's main goals are to make hospice care services more readily available to greater numbers of veterans and develop information about how VA might best offer these services.

The Committee bill would require VA to set up demonstration projects at 15 to 30 VA sites at which terminally ill veterans receive care by one of three means: (1) A hospice operated by a VAMC; (2) a non-VA hospice under contract with a VAMC pursuant to which any necessary inpatient care would be furnished at VA facilities; or (3) a non-VA hospice under contract with a VAMC with any necessary inpatient care to be furnished at non-VA facilities.

The Committee bill generally would require VA to follow Medicare's policy in setting reimbursement rates. Contract hospice rates would generally be capped at the Medicare rates. However, exceptions could be made in cases in which the Secretary determines that the Medicare rate would not compensate a non-VA hospice for providing a veteran with necessary care. In such a case, the Secretary could either pay a rate higher than the Medicare rate or provide in-kind services to the contract organization. The Committee included this provision in the bill in order to ensure that veterans for whom care is extraordinarily expensive due to the nature of their condition, such as veterans with AIDS, would not be excluded from the program.

Under the Committee bill, VA would be required to include at least 10 VAMCs that offer a less comprehensive range of services

to terminally ill veterans as part of the evaluation. In including a comparison group in the evaluation, the Committee seeks to determine whether furnishing a less comprehensive range of services constitutes a viable alternative at VAMCs in which the numbers of veterans desiring such services may not be sufficient to justify a full-scale hospice program. The Committee notes that the number of sites offering a less comprehensive range of services as proposed in the Committee bill is twice the number proposed in S. 1358 of the 102nd Congress. The Committee believes that increasing the number of control group sites should enable VA to evaluate the question of the appropriateness and desirability of a less comprehensive range of hospice-like services.

The Committee bill differs from S. 1358 of the 102nd Congress in two other significant respects. First, the Committee bill specifically would require that the Director of VA's Health Services Research and Development Service (HSR&D) conduct the evaluation of the various models for furnishing hospice care. This requirement should ensure that the study will be conducted by highly qualified researchers whose mission is objective research. In order to prevent the diversion of scarce funds from other equally meritorious health services research projects, the Committee bill would authorize the appropriation of additional funds to HSR&D to cover costs associated with the mandated evaluation.

In addition, in order to ensure that VA patient care is not compromised or diminished in any way by this pilot program, the Committee bill would provide expressly that VA is not precluded from furnishing hospice care services at VAMCs not participating in the pilot program or the control group. Indeed, the Committee encourages VA to not only maintain such services, but to expand the furnishing of hospice services at additional VA medical centers.

Cost: According to CBO, the enactment of section 203 would entail costs of $14 million in budget authority and outlays in fiscal year 1994 and total estimated costs of $78 million in budget authority and outlays in fiscal year 1994–1998.

Rural Health-Care Clinic Program

Section 204 of the Committee bill is substantively identical to S. 452, which in turn is substantively identical to title IV of S. 2575 of the 102nd Congress, which the Committee reported (S. Rpt. 102–401, pgs. 53–58) on September 15, 1992, and the Senate passed on October 1, 1992. The provisions of this section would require VA to establish a 3-year rural health care clinics pilot program under which VA would evaluate three alternatives for improving access to VA health care services for veterans living in rural areas remote from VA health care facilities.

Background

The Committee has long been interested in and concerned about the difficulties veterans living in rural areas face in gaining access to VA health care services. In July 1983 and again in November 1989, the Committee held hearings on this issue. At both hearings the Committee heard testimony about problems affecting veterans living in rural areas, including problems associated with travel distances, adverse weather conditions, and the availability of special-

ized health care services. Similar concerns were raised at field hearings the Committee held on July 1, 1991, and on July 19, 1993, to address West Virginia veterans' access to VA health care services.

One significant difference between urban and rural veterans is the greater obstacles they face in traveling to VA health care facilities. For example, in North Dakota over 34,000 veterans—more than 50 percent of the State's total veteran population—live in counties 100 miles or more from the only VA health care facility located in that State. The situation is even more severe in eastern Montana, where 83 percent of veterans live more than 100 miles from the nearest VA facility. In contrast, the Chicago metropolitan area has four VA medical centers, several of which are located on major public transportation routes.

Difficulties in traveling to VA health care services are not confined to veterans living 100 miles or more from the nearest VA health care facility. Although most West Virginia veterans live within 100 miles of one of that State's four VA health care facilities, rugged topography, poor roads, and sporadic public transportation combine to make it difficult for many veterans to reach those facilities. Veterans living in other mountainous States encounter similar difficulties.

For many years, the Committee has urged VA to explore alternatives for improving access to VA health care services for veterans living in rural areas and has supported various pilot programs designed to identify effective means for achieving that goal. In September 1986, the Senate Committee on Appropriations directed VA to establish a pilot program to test two different means for expanding VA health care services in rural areas (S. Rpt. No. 99–487, page 87). The Committee supported this directive, in response to which VA established two satellite, community-based clinics—one, in Redding, California, operated by VA personnel, which had 9,457 outpatient visits, and the other, in Farmington, New Mexico, operated by a nonprofit organization under contract with VA, which had 21,027 outpatient visits. Both clinics have been of great benefit to veterans living in these geographically remote areas.

The Committee also developed legislation enacted as section 113 of Public Law 100–322, on May 20, 1988, which required VA to implement a 2-year pilot program of mobile health care clinics, provided that funds were appropriated specifically for that purpose. Under that program, VA has purchased six appropriately equipped mobile vans for use in furnishing health care services to veterans in rural areas at least 100 miles from the nearest VA health care facility. The mobile clinics, which began providing care in October 1992, are based at VAMCs located in the following areas: Fayetteville/Durham, North Carolina; Poplar Bluff, Missouri; Prescott, Arizona; Spokane, Washington; Togus, Maine; and White River Junction, Vermont. As of March 1993, nearly 4,000 veterans had received care through these clinics.

The mobile clinics also played an invaluable role in the aftermath of Hurricane Andrew in Florida last year. Mobile clinics from Fayetteville, Prescott, and Spokane were sent to the hurricane damage site and 5,000 people received medical treatment.

Committee bill

The rural health care clinic pilot program provisions of the Committee bill are designed to further the Committee's commitment to exploring alternatives for improving access to VA health care services for veterans living in areas geographically remote from VA facilities. Such information may be even more critical to VA in the future, if, national health care reform calls for VA to compete directly with non-VA providers.

Under the rural health care clinic program, VA would be required, during the 3-year period of October 1993 to September 1996, to establish and evaluate three means for furnishing health care services to these veterans: (1) mobile health care clinics equipped, operated, and maintained by VA personnel, (2) part-time stationary clinics operated by VA personnel, and (3) part-time stationary clinics operated through contracts with non-VA entities. This program should enable VA to determine the geographic conditions and ranges of services for which mobile clinics or part-time stationary clinics may be more effective. In determining what health care services will be provided through rural health care clinics, the Committee expects VA to draw upon the experiences of VA and non-VA health care facilities which currently operate mobile clinics and part-time stationary clinics.

One model for furnishing health care services through a mobile clinic of which the Committee is aware is the Checkup and Routine Examinations (CARE) van operated by the Lebanon, Pennsylvania, VAMC. The CARE van augments the Lebanon VAMC's services by providing preventive screening examinations to veterans living in isolated farming and mountain communities in central Pennsylvania. The CARE van's staff refer veterans requiring followup treatment to the Lebanon VAMC or its satellite outpatient clinic in Harrisburg or, if the veteran chooses, to a private physician.

The strength of the mobile clinic approach is its flexibility. Such clinics can treat small, scattered veteran populations in remote areas where the workload is insufficient to justify establishment of a permanent clinic. They can be shifted among various locations to accommodate fluctuating demand and to provide veterans with convenient access to care.

However, the Committee recognizes that mobile clinics may not constitute the most effective means for furnishing health care services to veterans—at least not in all rural areas. Several VA medical centers which operated mobile clinics during the 1980s discontinued those programs due to difficulties regarding vehicle maintenance and recruitment and retention of staff. Thus, the Committee bill requires VA to establish both mobile and part-time stationary clinics and to evaluate both types of clinics.

Like mobile clinics, part-time stationary clinics can furnish various services depending on the needs of veterans living in particular remote areas. Several VA medical centers already operate programs comparable to the part-time stationary clinics envisioned by the Committee. For example, the Salt Lake City, Utah, VA Medical Center operates a program though which physicians employed by the Salt Lake City VAMC fly to VA medical centers in Grand Junction, Colorado, and in Fort Harrison and Miles City, Montana, several days each month to furnish specialized diagnostic and treat-

ment services that would otherwise be unavailable at those facilities. According to the Chief of Staff of the Salt Lake City VAMC, this program has proven to be very cost-effective because the cost of chartering an airplane to fly a group of specialist physicians to the three VA medical centers is considerably lower than the cost of transporting individual veterans from those locations to Salt Lake City.

Other VA medical centers have established part-time stationary clinics through which health care services are furnished by non-VA health care professionals. One of the most successful programs of this type is the Farmington, New Mexico, VA Community Clinic noted above. A joint venture between the Albuquerque VA Medical Center and Presbyterian Medical Service, the clinic furnishes a full range of ambulatory care services. Health services are provided by employees of Presbyterian Medical Services who refer veterans who require services not furnished by the clinic to the Albuquerque VAMC.

Unlike the mobile clinic pilot program established under Public Law 100–322, the rural health care clinic program would not restrict access to veterans living at least 100 miles from the nearest VA health-care facility. Instead, the Committee bill would authorize the Secretary to establish rural health care clinics in areas less than 100 miles from the nearest VA health care facility if the Secretary determines those places to be appropriate for furnishing such services. As noted previously, in many States, such as West Virginia, significant numbers of veterans who live in areas that are less than 100 miles from the nearest VA facility lack ready access to VA facilities because of poor roads or inadequate public transportation services.

To ensure that veterans across the nation have access to VA care through rural health care clinics, the Committee bill would prohibit VA from establishing more than one clinic under this pilot program in any one State. The Committee further recommends that VA establish at least two clinics in each of the four geographic regions into which the Veterans Health Administration is organized.

The Committee bill would require that at least three of the nine clinics established under the rural health care clinic program be mobile clinics. With regard to the other six clinics, the Secretary would have the discretion to determine what combination of mobile and part-time stationary clinics would be most appropriate to carry out the program's goals.

The Committee bill also mandates that VA carry out an evaluation of this program. The Secretary would be required to submit to Congress a report on the program, which would contain detailed descriptions of the types of health care services furnished under the program, the veterans who received services under the program, and the types of personnel who furnished these services, as well as an analysis of the costs associated with providing these services. The report would also assess the extent to which these clinics provide care to veterans who have not previously used the VA health care system.

In recognition of the fact that VA's health care programs face tight budget constraints, the Committee bill would prohibit VA

from expending funds for the rural health care clinic program unless funds are expressly appropriated for that purpose.

Cost: According to CBO, the enactment of section 204 would entail costs of $3 million in budget authority and outlays in fiscal year 1994 and total estimated costs of $18 million in budget authority and outlays in fiscal years 1994–1998.

Payment to States of Per Diem for Veterans Receiving Adult Day Health Care

Sections 205(a) and 205(b) of the Committee bill are derived from S. 852. Section 205(a) would authorize VA to provide per diem payments to State Veterans Homes for adult day health care furnished to veterans for whose care State Homes are eligible to receive per diem payments. Section 205(b) would authorize VA to provide grants to States for construction, remodeling, or expansion of State Home facilities for purposes of furnishing adult day health care.

Background

The State Veterans Home Program is a critical component of VA's long-term care efforts. Under this program, VA, pursuant to the provisions of subchapter V of chapter 17 of title 38, makes per diem payments to cover a portion of the cost of care provided to veterans in State homes and, pursuant to the provisions of subchapter III of chapter 81, provides grants to States for the construction, expansion, or remodeling of State-operated facilities furnishing long-term care to veterans. Nearly 16,500 veterans received care in State Homes during fiscal year 1992.

Under current law, VA is authorized to provide per diem payments and construction grants to State Homes for only three levels of care—hospital, nursing home, and domiciliary care. One important level of extended care which VA is not presently authorized to support is adult day health care (ADHC). ADHC is a therapeutically oriented, community-based, outpatient day program which provides health maintenance and rehabilitative services to frail elderly persons in a congregate setting. Health professionals and support staff help participants and their caregivers develop the knowledge and skills necessary to manage care requirements in the home.

The provision of ADHC during the daytime hours in a community setting enables many veterans to remain at home in a supportive environment among family and friends as an alternative to nursing home placement. For a growing number of veterans such as those suffering from Alzheimer's disease or depression, or requiring supervision and medication, ADHC provides the appropriate level of limited but essential health care services. ADHC also can offer an essential respite for veterans' primary caregivers and is particularly helpful to caregivers who must work outside the home.

The Committee received compelling testimony about the benefits of VA's own ADHC programs at its May 19, 1993, hearing on VA's geriatric and long-term care programs. Currently VA provides ADHC at 15 VA medical centers and through 28 contract providers. More than 2,000 patients were treated in VA ADHC programs in fiscal year 1992. During that period, the average daily census in

VA ADHC programs was 417 patients, with an average length of stay of 153 days at a per diem cost of $59.09. Contract ADHC programs had an average daily census of 206 patients, with an average length of stay of 124 days at a per diem costs of $58.12.

Committee bill

Section 205(a) of the Committee bill would amend section 1741 of title 38 to authorize VA to make per diem payments, at a rate determined by the Secretary, for each eligible veteran receiving adult day health care in a State Home.

Section 205(b) of the Committee bill would amend various sections of subchapter III of chapter 81 so as to authorize VA to provide grants to States to offset costs associated with expanding or remodeling State Veterans Home facilities for the purpose of furnishing ADHC services. VA would have no authority to provide grants for new construction for this purpose.

The Committee believes that the highly successful State Veterans Home program is well suited for this new mission. The 71 State Homes across the country already provide high quality hospital, nursing home, and domiciliary care to veterans in a cost-effective manner. State Home staff have considerable expertise in geriatrics and in working with veterans who have physical and mental disabilities, and are qualified to provide veterans with ADHC services. Moreover, because many State Homes are located in communities in which VA ADHC services are not available, enabling State Homes to provide adult day health care would improve veterans' access to that level of care.

Cost: According to CBO, the enactment of sections 205(a) and 205(b) of the Committee bill would entail costs of $6 million in budget authority and no outlays in fiscal year 1994, and a total of $23 million in budget authority and $16 million in outlays during the 5 year period from fiscal year 1994 through fiscal year 1998.

TITLE III—MISCELLANEOUS

Subtitle A—Education Debt Reduction Program

Program of Assistance in the Payment of Education Debts Incurred by Certain Veterans Health Administration Employees

Section 302 of the Committee bill is derived from S. 1122, as modified by an amendment by Senator Rockefeller.

Background

As the largest health care system in the United States, VA experiences, frequently to an expanded degree, many of the same problems in recruiting and retaining certain health care professionals as other providers.

Federal, State, and local agencies have developed various programs to help alleviate such shortages of health professionals. For example, the National Health Service Corps (NHSC) administers a loan repayment program that pays lenders up to $35,000 a year for a health professional's qualified educational debt. In return for this financial assistance, the Federal Government asks that the participant fulfill a service obligation—a minimum of 2 years—at a site

designated by the NHSC. Most NHSC sites are located in underserved rural and urban areas.

VA also has programs to help address recruitment and retention problems, including both scholarship and tuition reimbursement programs, under an overall health professionals' assistance program which is set forth in Chapter 76 in title 38.

VA's scholarship program, set forth in subchapter II of chapter 76, pays all expenses incurred by a student in an approved field of study at an accredited college or university, in return for which, the graduate agrees to work at VA for at least 2 years. Since the program's inception in 1982, 3,195 nurses, 115 occupational therapists, and 210 physical therapists have received assistance through this program.

The tuition reimbursement program set forth in subchapter III of chapter 76 helps current VA employees pay for educational expenses—up to $2,000 per year—for a course of training which leads toward an associate, bachelors, masters, or doctoral degree in nursing. An employee receiving assistance from the tuition reimbursement program must continue to work in a VA facility for at least 1 year after completing the course for which the participant received tuition reimbursement. This program, which has been of great benefit to VA employees who might not otherwise have been able to receive training that enhances not only their earning power but their value to VA as well, has assisted 13,362 VA employees to date.

Despite VA's efforts, however, a recent survey of health care occupations in VA demonstrated that problems still exist in certain geographic regions, occupations, and specialties. For example, Dallas, New York, and Los Angeles are three metropolitan areas with severe recruitment problems. Nationally, there is a 26 percent vacancy rate for physical therapists at VA hospitals. According to VA nursing service officials, all VAMCs have difficulties in attracting and keeping nursing personnel in the specialty areas of long-term care and geriatrics.

The scarcity of certain health professionals in particular regions of the country is sure to spread to other areas, since pending health care reform will emphasize primary care and thus increase the demand for primary care health providers.

The Committee believes that VA needs additional instruments to draw valuable health professionals to the VA system. The loan repayment program proposed in the Committee bill would complement the existing programs within VA and move one step further in ensuring an adequate supply of providers.

At the Committee's June 23, 1993, hearing, Senator Mikulski explained that this program represents a "post-service benefit" model, which will allow VA to spend more time concentrating on recruitment and retention and less time worrying about collecting service commitments from recipients. Senator Mikulski also emphasized the need to attract those health care professionals in fields requiring 2-year degrees such as medical lab technicians and nuclear medicine technicians. Under current law, VA cannot provide additional assistance to persons who have degrees from 2-year, community colleges, in professions in which serious recruitment and retention difficulties persist.

Also at the Committee's hearing, Dr. James W. Holsinger, Jr., VA's Under Secretary for Health, supported the educational loan reduction program and described the program as another valuable tool in recruiting and retaining health care professionals in demand. The American Nurses Association, the American Association of Nurse Anesthetists, and the Nurses Organization of Veterans Affairs submitted testimony in support of this proposal.

Committee bill

Section 302 of the Committee bill would establish a student loan repayment program for VA health care professionals (except physicians and dentists) who have completed or are completing a 2-year or 4-year course of training at an undergraduate institution or a course of training at a graduate institution that qualified or qualifies the individual for the position described in section 7402(b) of title 38, and who serve in occupations, specialties, or geographic areas where great difficulties in recruiting and retaining qualified employees have been determined to exist.

This provision would require a VA employee to enter into an agreement with the Secretary for each year in which the employee seeks assistance, under which the Secretary would agree to pay the lender holding the employee's student loan the lesser of $4,000 or the principal and interest owed by the employee, once the employee has completed the required year of service, and the employee would agree to serve for 1 year in such a position as a condition of receiving such assistance. By requiring direct payment to lenders, the Committee bill would ensure that funds appropriated for this program are used only for their intended purpose. The total amount of assistance available to an individual under the Educational Debt Reduction program would not exceed $12,000 and would be exempt from taxation.

This program is not designed to replace existing programs but would complement the assistance already available under the Scholarship and Tuition Reimbursement programs. An individual receiving benefits under this proposed new program would not be able to use years of service required to fulfill obligations under one program to satisfy obligations under the other programs. Furthermore, an employee would be required to maintain an acceptable level of job performance as a condition of receiving assistance.

Under the Committee bill, the Secretary would be required to report to Congress on the effectiveness of both the Education Debt Reduction Program and the Health Professional Scholarship Program in retaining VA health care professionals. The Secretary would be required to integrate this report with the annual report that the Secretary must submit to Congress concerning the Scholarship and Tuition Reimbursement Programs.

Finally, the Committee bill would authorize $10 million to VA for each of fiscal years 1994 through 1998 to carry out the Education Debt Reduction Program.

Cost: According to CBO, the enactment of section 302 would entail costs of $10 million in budget authority in fiscal year 1994 and total estimated costs of $35 million in budget authority and outlays in fiscal years 1994–1998.

Subtitle B—Other Provisions

Extension of Authority of Advisory Committee on Education

Section 311 of the Committee bill, which is derived from S. 1177—which in turn was derived from, and is substantively identical to, S. 2049 of the 100th Congress which the Committee reported on April 22, 1988, and the Senate passed on April 28, 1988, would amend section 3692 (c) of title 38, United States Code, by striking out "December 31, 1993" and inserting in lieu thereof "December 31, 1997".

Background

The Veterans' Advisory Committee on Education is an important element of VA's overall effort to provide America's veterans with quality educational benefits. The Advisory Committee is composed of persons who are eminent in the fields of education, labor, and management, representatives of institutions and establishments furnishing education to veterans and their families, and of veterans themselves.

The Advisory Committee works in consultation with the Secretary of Veterans Affairs on issues relating to the administration of educational benefits, and produces reports and recommendations on education to both the Secretary and Congress. Under current law, VA's authority to maintain the Veterans' Advisory Committee on Education expires December 31, 1993. The Committee on Veterans' Affairs believes that the Advisory Committee has an ongoing role in VA's efforts to deliver quality educational benefits to our Nation's veterans and should, therefore, be continued.

Committee bill

Section 311 of the Committee bill would extend VA's authority to maintain a Veterans' Advisory Committee on Education for 4 years, from December 31, 1993, to December 31, 1997.

Cost: According to CBO, section 311 has no significant cost.

Extension of Authority To Maintain Regional Office in the Philippines

Section 312 of the Committee bill, which is derived from S. 1177, would amend section 315(b) of title 38, United States Code, by striking out "March 31, 1994" and inserting in lieu thereof "September 30, 1995".

Background

The VA Regional Office in Manila administers programs to veterans in the Philippines, including the many Filipinos who served in or were attached to the United States Armed Forces during World War II. Approximately $182 million in benefits are paid annually through the Manila Regional Office, and operating a regional office in the Philippines continues to be the most cost-effective means of administering VA programs for beneficiaries who reside there.

The Committee gathered further confirmation of the need for continued operation of the Manila Regional Office through the General Accounting Office's report of July 15, 1993, entitled "Veterans'

Compensation: Premature Closing of VA Office in the Philippines Could Be Costly" (GAO/HRD–93–96).

Committee bill

Section 312 of the Committee bill would extend VA's authority to maintain a regional office in the Republic of the Philippines for 18 months, from March 31, 1994, to September 30, 1995.

Cost: According to CBO, the enactment of section 312 would entail costs of $1.2 million in budget authority and outlays for an additional 6 months in fiscal year 1994 and $2.4 million in budget authority and outlays for the 12 months in fiscal year 1995.

COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), estimates that the enactment of the provisions of S. 1030 would entail total costs of $1,362,000,000 in budget authority and $1,276,000,000 in outlays. The cost estimate provided by CBO, setting forth a detailed background of the costs, follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 19, 1993.

Hon. JOHN D. ROCKEFELLER IV,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1030, the Veterans Health Programs Improvement Act of 1993, as ordered reported by the Senate Committee on Veterans' Affairs on July 15, 1993.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1030.

2. Bill title: The Veterans Health Programs Improvement Act of 1993.

3. Bill status: As ordered reported by the Senate Committee on Veterans' Affairs on July 15, 1993.

4. Bill purpose: To improve the Department of Veterans Affairs (VA) program of sexual trauma counseling for veterans, to improve other VA health-care programs for women veterans, and for other purposes.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Direct spending:					
Estimated budget authority	(1)	(1)	(1)	(1)	(1)
Estimated outlays	(1)	(1)	(1)	(1)	(1)
Authorization:					
Estimated authorization of appropriations	115	151	160	158	171
Estimated outlays	79	136	156	171	173

[1] Less than $500,000.

Basis of estimate: The table above shows the estimated total cost of the bill. Tables in the following section-by-section cost analysis show the cost of individual sections or subsections.

The section-by-section analysis addresses only those sections of the bill that could be expected to have a significant budgetary impact.

Section 101. This section would mandate a number of revisions to the VA sexual trauma counseling and services program established by Public Law 102–585 in November 1992. The period during which counseling and services could be provided would be extended through calendar year 1998; veterans would no longer be required to seek assistance from VA within two years of discharge; and eligibility would be expanded to include male veterans. The section would also require VA to establish a nationwide 24-hour toll-free hotline for sexual trauma counseling.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	2	4	6	7	8
Estimated outlays	1	3	5	6	8

Because VA has begun implementing the original authorization, there are no program data yet available on the cost of or demand for sexual trauma counseling and services or on the characteristics of the veterans requesting counseling and services. The 1993 appropriation included $3 million for the sexual trauma program, but this amount only covered start-up costs. CBO estimated the cost of the current law sexual trauma program at around $7 million a year when fully operational. With the program expansions included in section 101, the cost of the program could increase to as much as $15 million by 1998, subject to the availability of appropriations.

Section 104. This section would significantly expand the authority of VA to provide gender-specific health services to women veterans. This authority was initially granted in Public Law 102–585. In addition to the services authorized in last year's legislation, section 104 would authorize pregnancy and fertility-related care and the use of contract care for these services.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	85	115	120	130	140
Estimated outlays	70	115	120	130	140

As with the sexual trauma program, VA is in the earliest stage of organizing the women's health services program enacted last year. The 1993 appropriation contained $4 million to establish four

pilot comprehensive centers for women's health care. The cost of the current program will depend on how extensively women's health services are offered throughout the VA system. CBO originally estimated the program to cost around $11 million a year.

The expansion of the women's health services program contained in section 104, however, is substantial. The aspect of this provision that would have the greatest impact on costs would be the authority to provide these services on a fee-for-service basis. This would enable women veterans to continue seeing their private physicians, while VA pays the bill.

As of July 1, 1992, there were 1.2 million female veterans. Based on data from VA's 1987 Survey of Veterans, it is estimated that approximately 41 percent of female veterans (around 474,000 women) have Category A eligibility for VA health care and, therefore, would be eligible for fee-basis gynecological and obstetrical care under section 104. The above cost estimate assumes that female veterans currently utilize these health services are the same rate and average cost as females of the same age in the general population.

The estimate further assumes that 60 percent of eligible veterans would participate in the program. However, the rate at which female veterans would seek care through the VA would depend on administrative factors. VA would have to establish a procedure for advance approval of the use of fee-basis services. The participation rate of eligible veterans would largely be a function of how complicated or difficult the approval process is.

Less than full-year costs would be anticipated in 1994 due to start-up delays in the fee-basis program.

Section 201. This section would extend through December 31, 2003, the period of eligibility of certain veterans for medical care from VA for the treatment of conditions that may be related to exposure to Agent Orange or ionizing radiation during military service. Such eligibility expires under current law on December 31, 1993.

Over the past few weeks, VA has provided five different estimates of the number of veterans who received VA care in 1992 for conditions that could be related to Agent Orange or radiation exposure. Based on these data, the cost of this authority in 1992 could have been as high as $200 million or as low as $2 million. Given the uncertainty surrounding 1992 spending, CBO cannot estimate with any degree of precision the likely spending levels in 1994–1998.

Section 202. This section would authorize VA to waive co-payments for medical care to veterans who were exposed to toxic substances while serving in the Persian Gulf theater of operations during the Persian Gulf War. VA would also be required, upon request, to refund any copayments paid to the agency by such veterans for care received since the war that would have been covered by this section.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated budget authority	(1)	(1)	(1)	(1)	(1)
Estimated outlays	(1)	(1)	(1)	(1)	(1)

[1] Less than $500,000.

According to Department of Defense data, about half of the 500,000 service members who served in the Persian Gulf theater have left the military and are now veterans. Based on the rate of use of VA medical services by veterans of similar age, it is expected that the number of Persian Gulf veterans seeking care from VA under this provision would be quite small. VA has estimated that less than $125,000 has been paid in copayments by these veterans.

Refunding the copayments paid by these veterans and exempting them from future copayments would reduce offsetting receipts and, therefore, would subject S.1030 to pay-as-you-go procedures. Because the number of veterans involved is expected to be small, the reduction in receipts is estimated to be less than $500,000 a year.

Section 203(a). This subsection would require VA to conduct a five-year pilot program of providing hospice care in VA facilities and under contract.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	7	7	8	8	9
Estimated outlays	7	7	8	8	9

The primary cost of the pilot program would be the provision of contract hospice care, because VA already operates hospice programs in a number of agency hospitals. This estimate assumes that the program would provide contract hospice care to 1,000 veterans and hospice care in VA facilities to approximately the same number of veterans as under current law.

The bill provides for VA to reimburse for contract hospice care on the same basis as Medicare. CBO has estimated the average Medicare reimbursement for hospice care in 1994 to be $6,775 per admission. Therefore, if the pilot program were set up to accommodate 1,000 patients a year, the cost would be approximately $6.8 million a year.

Section 203(d). This subsection would authorize appropriations in fiscal years 1994–1997 for the evaluation by VA of the hospice care pilot program.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Authorization of appropriations	1	3	2	(1)	0
Estimated outlays	(1)	2	3	1	0

[1] Less than $500,000.

The amounts specified were assumed to be fully appropriated and to be expended according to historical spending patterns for activities of this type.

Section 204. This section would authorize appropriations in 1994–1996 for the operation of a pilot program of rural health-care clinics, to include mobile clinics and part-time stationary clinics.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Authorization of appropriations	3	6	9	0	0
Estimated outlays	(1)	4	6	8	0

[1] Less than $500,000.

Authorization of a pilot program of mobile health care clinics expired in 1990. Under this authority, VA purchased 6 mobile clinics at a cost of nearly $700,000 each. Under general authority, VA operates more than 350 stationary satellite medical facilities, many of which provide care in remote rural areas.

This estimate assumes that all authorized amounts would be appropriated, and outlays were estimated according to the current spending patterns of these activities.

Section 205(a). This subsection would authorize the VA to establish a per diem payment to be made to state veterans' homes for each eligible veteran receiving adult day health care (ADHC) in the state home. The per diem rate would be set by VA.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	(1)	(1)	1	1	2
Estimated outlays	(1)	(1)	1	1	2

[1] Less than $500,000.

Based on the cost VA has experienced providing ADHC in its own facilities, the department estimates that the 1994 average daily cost of ADHC care in state homes would be about $66. The VA has requested legislative authority to provide assistance to state homes for the provision of ADHC at a per diem rate in 1994 of 25 percent of the agency average daily cost, or $16.50. This is the per diem rate assumed to be set by VA under section 205(a). The rate was increased in future years for anticipated inflation.

No state homes operate ADHC programs currently, although some state homes have expressed to VA an interest in providing this type of care. Because some lead time would be required to establish new programs, it is expected that the VA cost of ADHC assistance would not exceed $500,000 until 1996. This estimate assumes that the average number of participants per day would grow from around 50 in 1994 to 300 in 1998.

Section 205(b). This subsection would authorize VA to make grants to states for the renovation or expansion of state veterans' homes in order to provide ADHC programs.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	6	4	4	2	2
Estimated outlays	0	1	3	4	4

Although it is not possible to estimate with any precision the number of states that would apply for the new grants, this estimate assumes that 9 grants would be awarded in the first five years. The current average construction grant for state veterans' homes is $4.1 million, which covers projects ranging from renovations to the construction of new buildings. The estimate above assumes that the average ADHC grant would be only half this amount, because an ADHC grant should involve a considerably smaller construction project than the average current law grant. Outlays were estimated according to historical spending patterns.

Section 302. This section would authorize VA to establish a program of assistance to certain of the department's health-care per-

sonnel. Under the program, an eligible employee could be given up to $4,000 a year to reduce the amount of debt incurred by the employee in completing the education programs necessary to qualify for his or her present position. No employee could receive more than $12,000 in total payments under the program. Section 302 would authorize the appropriation of $10 million in each of fiscal years 1994–1998 for this program.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	10	10	10	10	10
Estimated Outlays	0	2	10	13	10

This estimate assumes that the amounts authorized would be fully appropriated. No funds would spend in the first year for which they are appropriated, because section 301 would require that, after an employee is selected for the program, a year of qualifying service must be performed before the yearly benefit would be paid. In addition, outlays from the 1994 appropriation are assumed to be delayed, because of the time needed to establish program requirements and regulations.

Section 312. This section would extend through fiscal year 1995, the authority of VA to maintain a regional office in the Philippines. The current authority expires on March 31, 1994.

[By fiscal years, in millions of dollars]

	1994	1995	1996	1997	1998
Estimated authorization of appropriations	1	2	0	0	0
Estimated Outlays	1	2	[1]	0	0

[1] Less than $500,000.

According to VA, the cost of operating the regional office in Manila for 6 months in 1994 would be $1.2 million and for 12 months in 1995 would be $2.4 million.

6. Pay-as-you-go-considerations: The Balanced Budget and Emergency Deficit Control Act, as amended, sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. Section 202 of S.1030 would reduce offsetting receipts, thereby subjecting the bill to pay-as-you-go procedures. The amount of the reduction, however, is not expected to be significant.

7. Estimated cost to state and local governments: Enactment of section 205 could increase the cost to states of operating state veterans' homes. For those states that choose to establish ADHC programs, the cost of operating state homes would increase to the extent that actual ADHC per diem costs exceed the federal per diem reimbursement rate. This estimate assumes that the federal per diem rate would cover 25 percent of total costs. Under this assumption, unreimbursed state costs would grow from around $300,000 in 1994 to nearly $5 million in 1998. Participation of a state home in the ADHC program, however, would be wholly voluntary.

States choosing to apply for a state home construction grant in connection with an ADHC program would be required to match the federal grant with an equal amount of state funds. Participation in this program is also voluntary.

8. Estimate comparison: None.

9. Previous CBO estimate: None.
10. Estimate prepared by: K.W. Shepherd.
11. Estimate approved by: Paul Van de Water for C.G. Nuckols, Assistant Director for Budget Analysis.

Regulatory Impact Statement

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any significant regulation of individuals or businesses or result in any significant impact on the personal privacy of any individuals and that, except as noted below, the paperwork resulting from enactment would be minimal.

In the cases of provisions requiring reports to the Congress to provide program data and evaluations (sections 101, 102, 104, 203, 204, and 302), the amount of paperwork would be reasonable in light of the beneficial objectives of the legislation.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at a meeting on July 15, 1993. On July 15, the Committee voted unanimously to report S. 1030 favorably to the Senate with an amendment in the nature of a substitute and subject to any subsequently adopted amendments.

Thereafter, the Committee considered four first degree amendments and one second degree amendment to the bill. The Committee adopted one of the first degree amendments and rejected three of the first degree amendments and the second degree amendment, as follows:

An amendment proposed by Senator Murkowski restricting the proposed authority for VA to furnish abortion services was rejected by a vote of 5–6, as follows:

YEAS—5	NAYS—6
Frank H. Murkowski	John D. Rockefeller IV
Alan K. Simpson	George J. Mitchell
Strom Thurmond	Daniel K. Akaka
Dennis DeConcini	Thomas A. Daschle
Bob Graham	Ben Nighthorse Campbell
	James M. Jeffords

An amendment proposed by Senator Daschle authorizing VA to furnish health care services, through September 30, 2003, to veterans exposed to environmental hazards while on active duty in the Persian Gulf theater, was approved by a vote of 8–3, as follows:

YEAS—8	NAYS—3
John D. Rockefeller IV	Frank H. Murkowski
Dennis DeConcini	Alan K. Simpson
George J. Mitchell	Strom Thurmond
Bob Graham	
Daniel K. Akaka	

Thomas A. Daschle
Ben Nighthorse Campbell
James M. Jeffords

A second degree amendment to Senator Daschle's amendment, proposed by Senator Murkowski, to limit access to services for such veterans and the time period during which services could be provided was rejected by a vote of 3–8, as follows:

YEAS—3	NAYS—8
Frank H. Murkowski	John D. Rockefeller IV
Alan K. Simpson	Dennis DeConcini
Strom Thurmond	George J. Mitchell
	Bob Graham
	Daniel K. Akaka
	Thomas A. Daschle
	Ben Nighthorse Campbell
	James M. Jeffords

An amendment proposed by Senator Murkowski relating to repeal of a provision in Public Law 102–585 which requires VA to establish designated smoking areas at VA health care facilities was rejected by a vote of 4–6, as follows:

YEAS—4	NAYS—6
Frank H. Murkowski	John D. Rockefeller IV
Alan K. Simpson	Dennis DeConcini
Strom Thurmond	Bob Graham
James M. Jeffords	Daniel K. Akaka
	Thomas A. Daschle
	Ben Nighthorse Campbell

An amendment proposed by Senator Murkowski that would have limited to 2 years, instead of the 10 years, the extension of entitlement to inpatient care for veterans exposed to Agent Orange or radiation was rejected by a vote of 3–8, as follows:

YEAS—3	NAYS—8
Frank H. Murkowski	John D. Rockefeller IV
Alan K. Simpson	Dennis DeConcini
Strom Thurmond	George J. Mitchell
	Bob Graham
	Daniel K. Akaka
	Thomas A. Daschle
	Ben Nighthorse Campbell
	James M. Jeffords

Agency Reports

On June 2, 1993, the Committee Chairman asked the Secretary of Veterans Affairs for a report setting forth the Department's views on S. 1030; on June 24, 1993, for a report setting forth the Department's views on S. 1122; on July 7, 1993, for a report setting forth the Department's views on S. 1094 and S. 1141; on July 22, 1993 for a report setting forth the Department's views on S. 852 and S. 452. As of the date of the filing of this report, only the reports setting forth the Department's views on S. 1122 and S. 1141 have been received and are reprinted below. However, on June 23,

1993, VA's Chief Medical Director, Dr. James W. Holsinger, Jr., submitted testimony on S. 852, S. 452, S. 1094, as introduced, and a draft of the women's health bill, and the testimony is reprinted below in lieu of Department's views.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, July 29, 1993.

Hon. JOHN D. ROCKEFELLER IV,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: We are pleased to provide you with the views of the Department of Veterans Affairs (VA) on S. 1122, a bill "[t]o authorize the Secretary of Veterans Affairs to carry out a program for repayment by the Secretary of certain education costs incurred by certain Veterans Health Administration employees, and for other purposes."

S. 1122 would authorize a new program to enhance VA's ability to retain certain scarce health care professionals. Under the program VA would agree to help pay an employee's student loan in exchange for a period of obligated services. VA would enter into an agreement with the employee to pay up to $4,000 per year of a loan incurred for education that qualified the person for VA employment. In exchange, the employee would agree to satisfactorily complete one year of employment with VA. Payment would be made only after completion of the one-year obligation. The maximum any employee could receive would be $12,000. Preference in the program would be accorded to employees in hard to recruit specialties. The program would not be available to physicians or dentists.

VA supports this initiative. The loan repayment program would help VA retain health-care personnel in a time when employees often work for VA for a period, and then move on to private sector positions. Administration of the program would be quite easy given that payments would not be made until completion of obligated service. VA suggests that the bill be amended so that this benefit would be available only for hard to recruit specialities. VA believes the intent is to use this recruitment and retention tool only where it is needed.

VA estimates the cost of this program to be $10,000,000 for Fiscal Year 1994 and $10,000,000 for each of the following four fiscal years, as authorized in the bill.

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on S. 1122 to the Congress.

Sincerely yours,

JESSE BROWN.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, July 29, 1993.

Hon. JOHN D. ROCKEFELLER IV,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: As you have requested, we are providing you with our views on S. 1141, a bill "to amend chapter 17 of title

38, United States Code, to require the Secretary of Veterans Affairs to conduct a hospice care pilot program and to provide certain hospice care services to terminally ill veterans."

This bill would require the Secretary to establish two different projects to furnish hospice care services to terminally ill veterans. The first project would require the Secretary to establish a five-year pilot program in not less than fifteen and not more than thirty Department facilities to determine the feasibility and desirability of furnishing hospice care services using three different mechanisms, including direct VA care and contract care. The second project would require the Secretary to provide much more limited palliative care to terminally ill veterans both directly and through contracting in not less than ten designated Department medical facilities. Both of these programs would entail significant and extremely detailed reporting requirements. We would have to evaluate both projects continuously and report annually to Congress regarding these evaluations. We note that this draft bill is essentially the same as S. 1358 in the 102nd Congress.

Depending on the actual number of participating sites established under the pilot project, we estimate the total cost of this five year pilot project to be between $3 million and $6 million dollars.

The Department strongly supports the furnishing of hospice care services to terminally ill veterans as the most effective and humane way to care for those who choose it. During the past two years, we have taken major steps to establish programs for the terminally ill in every VA health-care facility. We believe that we are operating excellent programs. Hence, we respectfully request that you reconsider the need for this legislation. Resources which would be expended for this program could best be used to enhance the programs we now operate.

Specifically, every VA Medical Center has in place a hospice consultation team, which is the heart of the program. The hospice consultation team consisting, at the minimum, of a physician, nurse, social worker, and a chaplain, exists to ensure that the patient receives hospice care. Each team consults with the patient's primary care team on pain management and other care issues. This team is also responsible for advising hospital management on policies and procedures related to the provision of hospice and palliative care. Each team develops and maintains expertise in the clinical care of the terminally ill patient and in the ethical issues involved in the care of the dying patient. The team also continually keeps abreast of Medicare and Medicaid hospice programs as well as local community hospice programs. Thirty-nine VA medical centers now provide hospice care in specially designated inpatient wards devoted exclusively to caring for the terminally ill. The decision to establish these in-patient wards is a management decision left to the individual facility which must consider, in part, bed availability. However, we note that Department facilities with separate in-patient hospice units are not providing better hospice care than those without such units; they are just providing the care in a different type of setting.

Hospice care is also provided to some veterans through community based home hospice care providers. In cases where Department facilities are not capable of furnishing such services to the

veteran economically because of geographical inaccessibility, VA purchases the care for the veteran by contract. Additionally, veterans aged sixty-five and older are ordinarily eligible for Medicare approved hospice programs. When home hospice care is available through Medicare approved programs, our medical centers refer patients to those programs.

In conclusion, VA is currently providing effective hospice and palliative care services either directly, by contract, or by referral, thereby successfully meeting the needs of the terminally-ill veteran.

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on S. 1141 to the Congress.

Sincerely yours,

JESSE BROWN.

STATEMENT OF JAMES W. HOLSINGER, JR., M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and members of the committee, I am pleased to be here to present the Department's views on seven different bills being considered by the Committee. They cover a wide range of subjects related to VA's provision of health care services. We support most provisions in the bills before the Committee, however there are some on which we recommend modifications, and others which we cannot support at this time.

S. 1030—SEXUAL TRAUMA COUNSELING

Mr. Chairman, I will begin by discussing the various provisions of S. 1030, your bill to improve the authority Congress provided VA last year to provide counseling to veterans who were victims of sexual trauma during service. We support the bill, and recommend that you consider modifying a few of its provisions.

The law enacted last year authorizes us to provide sexual trauma counseling services through December 31, 1995. It also imposes strict time limitations on our authority to contract for such counseling, on the windows of eligibility for women veterans seeking these counseling services, and on the maximum length of time a woman veteran may receive sexual trauma counseling. Your bill would extend both the program authority and the Secretary's contracting authority through December 31, 1998. It would also eliminate the time limitations relating to veterans' eligibility for sexual trauma counseling and repeal the time limitation regarding the period of receipt of counseling.

We strongly support extending this program. Indeed we recommend that you permanently authorize it by striking the sunset provision on both the program, and the contract authority. Our own task force on sexual trauma, and the Steering Committee of the National Women Veterans' Health Training Program, have advised us that a veteran's need for sexual trauma counseling often does not manifest itself until many years after the occurrence of sexual trauma. In addition, some victims of sexual trauma may be unable to seek counseling for many years, and some who receive counseling may need to return years later to deal with a recurrence

of anxiety or other symptoms. To prevent veterans from being denied the counseling needed for sexual trauma which occurred while they were on active duty, we believe that the time limits on the program should be removed.

We are also extremely concerned that those women discharged before December 31, 1991, not lose eligibility for counseling at the end of this year, as would be the case under existing law. We strongly support extending that time frame and recommend that you consider eliminating that time limitation entirely. We also support the provisions of the bill which would eliminate other time limitations included in the current program.

This bill would also eliminate all references to "women" in the current law, thereby extending eligibility for sexual trauma counseling services to male veterans who suffer sexual trauma while serving on active duty. We see no reason to discriminate on the basis of gender in the providing of this benefit, and we support this aspect of the bill. The measure would also increase the outpatient priority for care received by veterans eligible for sexual trauma counseling. We also support that provision.

We generally support the provisions of the bill pertaining to regional coordinators of women's services. We agree that regional coordinators should serve on a full-time basis. At this time, we have full-time persons in two of our regions, and we are actively recruiting persons for the other two regions. We also support clarifying that the coordinator is responsible for facilitating communication between the coordinators in each hospital, and between the Under Secretary of Health and the Secretary. We will give full support to the coordinators working in the field both in terms of funding, personnel, clerical support and communications needs.

The bill would also direct that we establish a new "800 number" phone system to provide information about the sexual trauma counseling program. We believe such a toll free number can be useful in conveying information about benefit programs, and to that end the Department already operates such a system with respect to all veterans benefits. We believe the best approach would be for VA to train our existing operators in the services available in the sexual trauma counseling program and allow them to serve the function contemplated by the bill. That would be considerably more cost-effective. Moreover, we would also be pleased to provide the Congress with any available information needed about the phone system use in lieu of fulfilling the reporting requirement contained in the bill.

Finally, we want to express some concern with the new report requirement pertaining to the difficulties veterans encounter in obtaining service-connection for disabilities relating to sexual trauma. Developing and assembling such information would be difficult, and we believe resources might be better used for other purposes.

DRAFT BILL—WOMEN'S HEALTH CARE

Mr. Chairman, I next turn to your draft bill which pertains to women veterans and their health care needs.

We support two parts of the draft bill without changes. First, the draft bill would authorize us to contract for outpatient care for women veterans when we either lack the capability to provide the

care in our own facilities, or cannot provide the care economically in our facilities because they are geographically remote from the patient. We already have authority to contract for hospital care for women in those circumstances, and this provision would extend the authority to ambulatory care.

Second, the draft bill would require that we prescribe quality assurance and quality control standards for the provision of mammograms. The standards must, to the extent practicable, conform to similar standards promulgated by the Department of Health and Human Services. We support enactment of this requirement.

Another provision in the draft bill would expand the requirements for a population study of women veterans authorized last year by Public Law 102–585. We do not object to the measure. I would note, however, that we have not begun work on this study because the law provided that we could carry it out only if Congress specifically appropriated money to do it. No such appropriation has been made.

Public Law 102–585, enacted last year, clarified that we have authority to provide various female gender specific services such as pap smears, breast examinations, mammography, and general reproductive health care. That law specifically prohibited the furnishing of infertility services, abortions, or care for pregnancy. This draft bill would change the law to authorize us specifically to provide "comprehensive reproductive health care, including pregnancy-related care," and to provide for "the management of infertility."

To authorize VA to provide comprehensive reproductive care as described in the draft bill would be a significant departure from past practice. We are not now equipped to provide those services; we do not have staff or facilities to provide obstetrical care. Although we have not had the opportunity to estimate costs to provide such care, I am certain they would be considerable. More importantly, however, we are awaiting the unveiling of the President's plans for national health care reform. To some extent, new directions for VA will be governed by those plans. Until we know how the President's proposal will impact on VA, we cannot support a proposal to authorize broad new responsibilities like that contained in this draft bill.

We ask that two final provisions in the draft bill be reconsidered. One of those would add additional detailed requirements for a report VA must make on women's health care and research, a report required of VA by Public Law 102–585. Compliance with the additional reporting requirements, because they are so broad, would be extremely burdensome and expensive. The second provision would expand and clarify the actions the Secretary must take to foster and encourage research involving women. Public Law 102–585 required the Secretary to "encourage the initiation and expansion of research relating to the health of veterans who are women." This draft bill would provide that to do that, the Secretary must consult with various parties identified in the draft bill, and it further suggests that research be conducted in some eight specific areas. Over the years, we have regularly taken the position that the research we undertake should not be conditioned, but should be approved on the basis of normal merit review processes.

S. 1094—AGENT ORANGE AND IONIZING RADIATION TREATMENT AUTHORITY

Mr. Chairman, we currently have unique authority to provide veterans with hospital and nursing home care for disabilities which may be related to their exposure to Agent Orange, or to ionizing radiation. The authority will expire at the end of this year, and S. 1094 would extend it for ten years through the year 2003. As you know, Congress first granted VA the special authority in 1981, at a time when we lacked knowledge about the effects of exposure to both Agent Orange and radiation. Congress believed VA should provide treatment to veterans who might have disabilities resulting from exposure while answers were sought to questions about the effect of exposure. Unfortunately, we continue to lack definitive answers. This summer the National Academy of Science will submit its report on the health effects of Agent Orange. We recommend that the authority be extended for two more years so that we will have time to consider whether a long-term extension is warranted in light of the NAS report. This alternative recognizes the NAS effort and does not preclude further extensions of the Agent Orange eligibility after 1995.

S. 852—ADULT DAY HEALTH CARE IN STATE HOMES

Mr. Chairman, I next turn to a bill introduced by Senator Conrad, S. 852, which would enhance the ability of States to offer adult day health care programs in State homes. The bill would authorize us to pay states a per diem, at a rate to be determined by the Secretary, for veterans who receive such care in a State Home. It would also authorize construction grants to states for use in developing facilities to furnish such care.

Adult day health care as furnished in VA facilities generally refers to the provision of health and health-related services, in a congregate setting, during daytime hours. In such programs, services provided include medical, nursing, rehabilitative, social, recreational, and educational services. Adult day health care enables individuals to continue living at home, rather than in a nursing home or other institutional setting. As now configured, State Veterans Homes provide hospital, nursing home, and domiciliary care in facilities owned and operated by the states. There are currently 71 such facilities in 41 states. VA contributes toward the cost of constructing and renovating the facilities through a grant program, and also helps pay operational costs by paying states a per diem for veterans living in the facility.

We certainly support the concept of extending adult day health care, but we do not know if providing it through State homes is cost-effective. Accordingly, we suggest deferring action until VA can undertake and complete a cost-effectiveness study.

S. 452—RURAL HEALTH CARE CLINICS PROGRAM

Mr. Chairman, S. 452 would direct that VA expand its efforts to provide care to veterans living in areas geographically remote from VA health care facilities. It would require that we establish what amounts to a pilot program to furnish care through both mobile health-care clinics, and part-time stationary clinics. Although we

strongly support efforts to serve veterans living in remote and rural areas, and are attempting to improve services to those veterans, we cannot support S. 452.

Specifically, the bill would require that we establish a three-year program under which we would establish at least nine new clinics to furnish care to veterans in areas located more than 100 miles from an existing Department facility. We could also furnish care in other less remote areas if the Secretary deems it appropriate. At least three clinics would have to be established each year and at least one of those would have to be a mobile clinic. Eligibility for care in the clinics would be the same as eligibility for outpatient care in any VA facility. Finally, the bill would require that we evaluate the program at the end of three years and report to Congress. The bill would authorize expenditures for the program of $3 million in Fiscal Year 1994, $6 million in Fiscal Year 1995, and $9 million in Fiscal Year 1996, but would also provide that no funds could be expended for the program unless expressly provided for in an appropriations Act.

Mr. Chairman, late last year, we placed six mobile health care clinics in operation under a program authorized in 1988 by Public Law 100–322. Implementation of that program was time consuming due to the lengthy period required to contract for mobile clinics and have them built. We are conducting a thorough evaluation of the operation of the existing clinics, as required by law, and will report to Congress on their effectiveness in July 1994, with a final report due in February 1995. There are questions about the reliability, durability, and expense of such clinics, and we strongly believe the Department should not embark on the purchase of additional units until completion of the evaluations.

With respect to free standing clinics, the Department has well established planning criteria used to determine when and where clinics should be established. We ask the Committee to refrain from overriding our existing planning tools and directing the Department to establish new stationary clinics under a separate pilot program.

DRAFT BILL—HOSPICE CARE PROGRAM

This draft bill would direct the Secretary to undertake two different projects to furnish hospice care services to terminally ill veterans. The first project would be a five-year pilot program to determine the feasibility and desirability of furnishing such services. We would furnish complete hospice care services at between 15 and 30 medical centers using three different mechanisms including direct VA care, and contract care. The second project would involve our furnishing much more limited palliative care to veterans, both directly and through contracting. We would have to evaluate both projects continuously and report annually to the Congress regarding the evaluations. The draft bill is essentially the same as S. 1358 in the 102nd Congress.

The Department strongly supports the furnishing of hospice care services to terminally ill veterans as the most effective and humane way to care for those who choose it. Two years ago we testified before this committee on the subject of hospice care, and we frankly had to admit that although we supported the provision of hospice,

we did not have adequate programs. In the ensuing two years, we have taken major steps to establish programs for the terminally ill in every one of our health-care facilities. We believe we are operating excellent programs and respectfully request that you reconsider the need for new legislation in this area. In addition, we believe resources which would be expended for this program would be best used to enhance the programs we now operate. I want to briefly describe those programs.

Hospice actually refers to how one delivers care to the terminally ill patient. Every medical center in our system has in place a hospice consultation team, which is the heart of the program. The consultation team exists to make certain that the patient receives "hospice" care. The team includes, at a minimum, a physician, a nurse, a social worker, and a chaplain. Each team consults with the patient's primary care team on pain management and other care issues. Additionally, the team is responsible for advising hospital management on policies and procedures related to provision of hospice and palliative care. Each team develops and maintains expertise in the clinical care of the terminal patient, and in the ethical issues involved in the care of the dying patient. Finally, the team keeps constantly abreast of developments in Medicare and Medicaid hospice programs as well as local community hospice programs.

Some VA medical centers operate specially designated inpatient wards devoted exclusively to caring for the terminally ill. Thirty nine of our facilities now provide such inpatient hospice programs. Whether to operate such an inpatient unit is left to individual medical center management and is somewhat dependent on bed availability. I want to emphasize, however, that we are providing hospice care in all of our facilities. Those facilities with separate inpatient hospice units are not providing better hospice care than those without units they are just providing the care in a different type of setting.

Hospice care is also provided to some veterans through community based home hospice care providers. In cases where veterans are eligible for contract care, VA purchases the care for them. Additionally, veterans over the age of sixty-five are ordinarily eligible for Medicare benefits. When home hospice care is available through Medicare approved programs, our medical centers refer patients to those programs.

S. 1122—EDUCATION DEBT REDUCTION ACT

Mr. Chairman, S. 1122 would authorize a new program to enhance our ability to retain certain scarce health care professionals. Under the program VA would agree to help pay an employee's student loan in exchange for a period of service obligation. VA would enter into an agreement to pay up to $4,000 per year of service to help pay a loan the employee incurred for education that qualified the person for the VA employment. In exchange, the employee would agree to satisfactorily complete one year of employment. Payment would be made only after completion of the one-year obligation. The maximum any employee could receive would be $12,000. Preference in the program would be accorded to employees

in hard to recruit specialties. The program would not be available to physicians or dentists.

VA supports this initiative. The loan repayment program would help us to retain health care personnel in a time when employees often work for us for a period, and then move on to private sector positions. Administration of the program would be quite easy given that payments would not be made until completion of obligated service. We suggest that the bill be amended so that this benefit would be available only for hard to recruit specialities. We believe your intent is to use this recruitment and retention tool only where it is needed.

Mr. Chairman, this completes my testimony. I would be pleased to respond to questions.

MINORITY VIEWS OF SENATORS MURKOWSKI, SIMPSON, AND THURMOND

While there are many worthy provisions in the Committee bill, we cannot support provisions of this legislation which would mandate Federal funding for abortions, provide a priority for the outpatient care for certain Persian Gulf veterans and victims of sexual trauma that is higher than other worthy veterans such as former POWs, and extend mandatory VA health care for veterans who believe they are ill as a result of exposure to Agent Orange or radiation for ten years rather than for two years.

Further, we are deeply concerned with the message this legislation—and the Committee's actions as a whole—sends to veterans. There appears to be a trend towards enacting piecemeal expansion of programs and segmented eligibility reform without our knowing what shape national health care reform will take and its effects on VA. We believe this could result in unfair rules governing access to VA care and disjointed programs for providing that care.

COMPREHENSIVE REPRODUCTIVE HEALTH-CARE SERVICES

We are deeply concerned with provisions of the Committee bill which would authorize "comprehensive reproductive health services" for women veterns—including abortion services and pregnancy related care. VA is currently mandated to provide care for disability and disease. Expanding this mandate to include abortion services represents a fundamental change in VA health care. The Committee would make this change for only one segment of the veteran population with no notion of the impact on current VA services or on VA services that may change under comprehensive national health care.

The VA testified before the Committee regarding the comprehensive reproductive health services provision. The Under Secretary for Health, Dr. Holsinger stated, "We are not now equipped to provide those services; we do not have staff or facilities to provide obstetrical care," and "* * * I am certain they [costs] would be considerable." Dr. Holsinger stated that VA would, therefore, contract for these services. The Committee did not authorize additional funding for in-house or contract care for these services; thus, providing the services by contract will cause a cost shift from other VA health-care services.

We do not believe that a veterans' health-care bill is the proper forum to reverse the long-standing Federal policy limiting the expenditure of taxpayer funding for abortions. The question is not one of being "pro-life" or "pro-choice." The question is whether veterans are well served by the Veterans' Affairs Committee, and its legislation, as a means to influence the debate. Further, we must address the true ramifications of our actions—that this legislation would not just make taxpayer-funded abortion services available as

a "choice" or "option" for those veterans VA is required to treat, but, in essence, we would be creating an entitlement.

Senator Murkowski offered an amendment to require VA to follow the so-called "Hyde amendment", that is, to limit abortions to cases of rape and incest, or when the life of the mother is in danger. The Hyde amendment has controlled Medicaid abortion policy for the past 17 years, and was recently re-endorsed in the House by a wide majority. However, the Murkowski amendment failed by a vote of 6 to 5 in our Committee. Senators DeConcini and Graham joined Senators Murkowski, Simpson, and Thurmond in supporting the amendment.

Priority for Outpatient Care

Two provisions of the Committee bill would create "super-priority" for outpatient health care services for specific groups of veterans. Section 202(b) would place Persian Gulf veterans who claim illness as a result of exposure to environmental hazards during Operation Desert Storm in the mandatory category for ambulatory care for conditions determined to be related to that exposure. Senator Murkowski offered an amendment to place these Persian Gulf veterans in the same eligibility category as veterans exposed to Agent Orange and ionizing radiation. This amendment failed by a vote of 8 to 3.

A separate provision (section 101(f) of the Committee bill would place veterans who claim they were sexually assaulted while serving on active duty in the mandatory category for outpatient counseling and treatment for conditions related to the assault.

While Senator Murkowski offered only the one amendment, we object to both provisions because they are unfair to other deserving veterans who are not in the mandatory eligibility category for outpatient care (such as former POWs) by placing these veterans ahead in the line for access to VA care. Access to, and priority for, outpatient care should be dealt with in a fair and comprehensive manner through general eligibility reform rather than on a piecemeal, group by group, basis.

Last year, former Secretary Derwinski established a task force to address eligibility reform which presented Congress with four alternative plans to manage and improve continuity of care in VA. These proposals were put on hold, and this Committee has not addressed eligibility reform in anticipation of national health care reform. Yet, by proposing ad hoc "super-priorities", the Committee is initiating piecemeal reform and placing service-connected and other groups of veterans in direct competition with each other for care and services. Since no additional resources are available to accommodate a new mandate for VA care, the high-priority care provided under the Committee bill would come at the expense of veterans new served by VA.

Agent Orange Extension

Finally, we support a two year extension for mandatory VA health care for veterans exposed to Agent Orange or ionized radiation, rather than the 10 year extension proposed in the Committee bill. Senator Murkowski offered an amendment that would have ex-

tended current law for two years. This amendment failed by a vote of 8 to 3.

Congress directed the National Academy of Science's Institute of Medicine to report to Congress at two year intervals over the next decade on diseases which can be associated with exposure to herbicides, with specific regard for the effects of possible exposure during Vietnam service. The first of those reports was recently released. We believe it would be prudent to review NAS's findings and extend the health care authorization appropriately rather than preempt the options of a future Congress. We believe that Congress will react quickly if NAS reports additional positive associations. VA stated in its formal testimony before this Committee that it supported a two year extension as well.

MINORITY VIEWS OF SENATORS MURKOWSKI, SIMPSON, THURMOND, AND JEFFORDS

SMOKING IN VA HOSPITALS

Last year, Congress required VA to establish elaborate indoor smoking areas in its medical facilities. Implementation was delayed until GAO could report on the cost and feasibility of establishing these areas. GAO found that for each facility to have its desired number of smoking rooms which meet the criteria established in the law (separate ventilation, negative air flow), VA would need to construct/renovate approximately 1,000 smoking rooms at a cost of up to $24 million. This estimate does not include costs associated with up-keep of the smoking areas, security, patient monitoring or other VA supervision of these areas. VA recently issued a directive announcing to medical facilities that they will be funded in FY 1993 up to $25,000 to establish smoking rooms.

Senator Murkowski offered an amendment to the Committee bill to repeal the mandatory requirement that VA construct and operate indoor smoking areas in its medical facilities. The amendment failed by a vote of 6 to 4. Senator Mitchell abstained from the vote.

We oppose implementation of this statute for the following reasons:

—The health effects of smoking are well known. The purpose of the VA health care system should be to cure illness and disease. VA, as a health care institution, should not be obligated to promote or even condone smoking—the effect of the current requirement to construct smoking rooms. Repeal of the statutory mandate for indoor smoking areas would still leave VA with discretion to allow smoking if appropriate.

—Current law requires VA to act irrespective of funding. Funds to construct or renovate smoking rooms would likely come out of the medical care account, therefore shifting funds available for other health care services.

—Last year, the effective date of the law requiring that VA provide indoor smoking facilities was delayed to allow Congress an opportunity to review the GAO report on cost and feasibility. Based on GAO's conclusion that establishing smoking areas meeting statutory requirements would be very costly, we believe the mandate should be rescinded.

—In the 102nd Congress, the Senate never debated this smoking provision. It was passed by the House and subsequently accepted by the Senate, ironically, as part of an omnibus veterans' health-care bill. It was never separately voted on by Members of the Senate.

Requiring an agency to spend money for the purpose of enabling sick patients to smoke is bad medical and public policy under any circumstance. The Senate needs to take action to right what is clearly a wrong and remove this mandate.

CHANGES IN EXISTING LAW MADE BY S. 1030 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 3—DEPARTMENT OF VETERANS AFFAIRS

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§ 315. Regional offices

(a) * * *

(b) The Secretary may maintain a regional office in the Republic of the Philippines until [March 31, 1994.] *September 30, 1995.*

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

1710. Eligibility for hospital, nursing home, and domiciliary care.

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1720D. [Counseling to women veterans] *Counseling, care, and services* for sexual trauma.

1720E. Rural health-care clinics: pilot program.

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SUBCHAPTER VII—HOSPICE CARE PILOT PROGRAM; HOSPICE CARE SERVICES

1761. Definitions.
1762. Hospice care: pilot program requirements.
1763. Care for terminally ill veterans.
1764. Information relating to hospice care services.
1765. Evaluation and reports.

Subchapter I—General

§ 1701. Definitions

For the purposes of this chapter—
(1) * * *

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health services, *women's health services,* and (except under the conditions described in section 1712(a)(5)(A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(I) of the service-connected disability of a veteran pursuant to section 1712(a) of this title, and

(II) in the discretion of the Secretary, of the non-service-connected disability of a veteran eligible for treatment under section 1712(a)(5)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title); and

(ii) in the case of an individual who was a recipient of services under subclause (i) of this clause at the time of—

(I) the unexpected death of the veteran; or

(II) the death of the veteran while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary,

such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist such individual with the emotional and psychological stress accompanying the veteran's death.

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title shall be eligible for the same medical services as a veteran.

* * * * * * *

(10) The term "women's health services" means health care services provided to women, including counseling and services relating to the following:

(A) Papanicolaou tests (pap smear).

(B) Breast examinations and mammography.

(C) Comprehensive reproductive health care, including pregnancy-related care.

(D) The management of infertility.

(E) The management and prevention of sexuality-transmitted diseases.

(F) Menopause.

(G) Physical or psychological conditions arising out of acts of sexual violence.

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§ 1703. Contracts for hospital care and medical services in non-Department facilities

(a) * * *

(1) * * *

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(9) Women's health services for veterans on an ambulatory or outpatient basis.

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Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

(a)(1) The Secretary shall furnish hospital care, and may furnish nursing home care, which the Secretary determines is needed—

(A) to any veteran for a service-connected disability;

(B) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

(C) to a veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;

(D) to a veteran who has a service-connected disability rated at 50 percent or more, for any disability;

(E) to any other veteran who has a service-connected disability, for any disability;

(F) to a veteran who is a former prisoner of war, for any disability;

(G) to a veteran exposed to a toxic [substance of] *substance,* radiation, *or environmental hazard,* as provided in subsection (e) of this section;

(H) to a veteran of the Mexican border period or World War I, for any disability; and

(I) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

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(e)(1)(A) * * *

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(C) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds may have been exposed while serving on active duty in the Southeast Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard (including petrochemicals, the fumes of burning landfills or petrochemicals, pharmaceuticals or other chemical agents administered by the Department of Defense, indigenous diseases, pesticides, and inhalation or ingestion of depleted uranium or wounds caused by depleted uranium) is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(2) Hospital and nursing home care may not be provided under subsection (a)(1)(G) of this section with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in subparagraph [(A) or (B)] *(A), (B), or (C)* of paragraph (1) of this subsection.

(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(1)(G) of this section after December 31, [1993.] *2003, or, in the case of care for a veteran described in paragraph (1)(C), after September 30, 2003.*

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§ 1712. Eligibility for outpatient services

(a)(1) Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—

(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service);

(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more; [and]

(C) to any veteran for a disability for which the veteran is in receipt of compensation under section 1151 of this title or for which the veteran would be entitled to compensation under that section but for a suspension pursuant to that section (but in the case of such a suspension, such medical services may be

furnished only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in that [section).] *section); and*

(D) during the period before October 1, 2003, for any disability in the case of a veteran who served on active duty in the Southeast Asia theater of operations during the Persian Gulf War and who the Secretary finds may have been exposed to a toxic substance or environmental hazard (including petrochemicals, the fumes of burning landfills or petrochemicals, pharmaceuticals or other chemical agents administered by the Department of Defense, indigenous diseases, pesticides, and inhalation or ingestion of depleted uranium or wounds caused by depleted uranium) during such service, notwithstanding that there is insufficient medical evidence to conclude that the disability may be associated with such exposure.

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(7) Medical services may not be furnished under paragraph (1)(D) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in that paragraph.

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(i) The Secretary shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, unless compelling medical reasons require that such care be provided more expeditiously:

(1) To a veteran *(A)* who is entitled to such services under paragraph (1) or (2) of subsection (a) of this [section.] *section, or (B) who is eligible for counseling and care and services under section 1720D of this title, for the purposes of such counseling and care and services.*

(2) To a veteran (A) who has a service-connected disability rated at less than 30-percent [disabling,] *disabling or* (B) who is being examined to determine the existence or severity of a service-connected [disability, or (C) who is eligible for counseling under section 1720D of this title, for the purposes of such counseling.] *disability.*

* * * * * * *

§ 1720D. [Counseling to women veterans] *Counseling, care, and services* for sexual trauma

(a)(1)*(A)* During the period through December 31, [1995,] *1998,* the Secretary may provide counseling to a [woman] veteran who the Secretary determines requires such counseling to overcome psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty.

(B) During the period referred to in subparagraph (A), the Secretary may provide appropriate care and services to a veteran for an

injury, illness, or other psychological condition which the Secretary determines to be the result of a physical assault, battery, or harassment referred to in that subparagraph.

[(2) To be eligible to receive counseling under this subsection, a veteran must seek such counseling from the Secretary within two years after the date of the veteran's discharge or release from active military, naval, or air service.]

[(3)] *(2)(A)* In furnishing counseling to a veteran under this subsection, the Secretary may, during the period through December 31, [1994,] *1998,* provide such counseling pursuant to a contract with a qualified mental health professional if [(A)] *(i)* in the judgment of a mental health professional employed by the Department, the receipt of counseling by that veteran in facilities of the Department would be clinically inadvisable, or [(B)] *(ii)* Department facilities are not capable of furnishing such counseling to that veteran economically because of geographical inaccessibility.

(B) The Secretary may provide care and services to a veteran under paragraph (1)(B) pursuant to a contract with a qualified non-Department health professional or facility if Department facilities are not capable of furnishing such care and services to that veteran economically because of geographic inaccessibility.

[(b) In providing services to a veteran under subsection (a), the period for which counseling is provided may not exceed one year from the date of the commencement of the furnishing of such counseling to the veteran. However, the Secretary may authorize a longer period in any case if, in the judgment of the Secretary, a longer period of counseling is required.]

[(c)] *(b)*(1) The Secretary shall give priority to the establishment and operation of the program to provide counseling *and care and services under* subsection (a). In the case of a veteran eligible for [such] counseling [who requires other care or services under this chapter for trauma described in] *and care and services under* subsection (a)(1), the Secretary shall ensure that the veteran is furnished counseling under this section in a way that is coordinated with the furnishing of such [other] care and services under this chapter.

(2) In establishing a program to provide counseling under subsection (a), the Secretary shall—

(A) provide for appropriate training of mental health professionals and such other health care personnel as the Secretary determines necessary to carry out the program effectively;

(B) seek to ensure that such counseling is furnished in a setting that is therapeutically appropriate, taking into account the circumstances that resulted in the need for such counseling; and

(C) provide referral services to assist [women] veterans who are not eligible for services under this chapter to obtain those from sources outside the Department.

[(d)] *(c)* The Secretary shall provide information on the counseling *and care and services* available to [women] veterans under this section. Efforts by the Secretary to provide such information—

(1) [may] *shall* include establishment of an information system involving the use of a toll-free telephone number (commonly referred to as an 800 number), and

(2) shall include coordination with the Secretary of Defense seeking to ensure that [women] *individuals* who are being separated from active military, naval, or air service are provided appropriate information about programs, requirements, and procedures for applying for counseling *and care and services* under this section.

[(e)] *(d)* In this section, the term "sexual harassment" means repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.

§ 1720E. Rural health-care clinics: pilot program

(a) During the three-year period beginning on October 1, 1993, the Secretary shall conduct a rural health-care clinic program in States where significant numbers of veterans reside in areas geographically remote from existing health-care facilities (as determined by the Secretary). The Secretary shall conduct the program in accordance with this section.

(b)(1) In carrying out the rural health-care clinic program, the Secretary shall furnish medical services to the veterans described in subsection (c) through use of—

(A) mobile health-care clinics equipped, operated, and maintained by personnel of the Department; and

(B) other types of rural clinics, including part-time stationary clinics for which the Secretary contracts and part-time stationary clinics operated by personnel of the Department.

(2) The Secretary shall furnish services under the rural health-care clinic program in areas—

(A) that are more than 100 miles from a Department general health-care facility; and

(B) that are less than 100 miles from such a facility, if the Secretary determines that the furnishing of such services in such areas in appropriate.

(c) A veteran eligible to receive medical services through rural health-care clinics under the program is any veteran eligible for medical services under section 1712 of this title.

(d) The Secretary shall commence operation of at least three rural health-care clinics (at least one of which shall be a mobile health-care clinic) in each fiscal year of the program. The Secretary may not operate more than one mobile health-care clinic under the authority of this section in any State in any such fiscal year.

(e) Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the Secretary's plans for the implementation of the pilot program required under this section.

(f) Not later than December 31, 1997, the Secretary shall submit to Congress a report containing an evaluation of the program. The report shall include the following:

(1) A description of the program, including information with respect to—

(A) The number and type of rural health-care clinics operated under the program;

(B) the States in which such clinics were operated;

(C) the medical services furnished under the program, including a detailed specification of the cost of such services;

(D) the veterans who were furnished services under the program, setting forth (i) the numbers and percentages of the veterans who had service-connected disabilities, (ii) of the veterans having such disabilities, the numbers and percentages who were furnished care for such disabilities (iii) the ages of the veterans, (iv) taking into account the veterans' past use of Department health-care facilities, an analysis of the extent to which the veterans would have received medical services from the Department outside the program and the types of services they would have received, and (v) the financial circumstances of the veterans; and

(E) the types of personnel who furnished services to veterans under the program, including any difficulties in the recruitment or retention of such personnel.

(2) An assessment by the Secretary of the cost-effectiveness and efficiency of furnishing medical services to veterans through various types of rural clinics (including mobile health-care clinics operated under the pilot program conducted pursuant to section 113 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 38 U.S.C. 1712 note)).

(3) Any plans for administrative action, and any recommendations for legislation, that the Secretary considers appropriate.

(g) For the purpose of this section, the term "Department general health-care facility" has the meaning given such term in section 1712(i)(2) of this title.

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Subchapter V—Payments to State Homes

§ 1741. Criteria for payment

(a)*(1)* The Secretary shall pay each State at the per diem rate of—

[(1)**]** *(A)* $8.70 for domiciliary care; and

[(2)**]** *(B)* $20.35 for nursing home care and hospital care,

for each veteran receiving such care in a State home, if such veteran is eligible for such care in a Department facility.

(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving adult day health care in a State home, if such veteran is eligible for such care under laws administered by the Secretary.

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Subchapter VII—Hospice Care Pilot Program; Hospice Care Services

§ 1761. Definitions

For the purposes of this subchapter—

(1) The term "terminally ill veteran" means any veteran—

(A) who is (i) entitled to receive hospital care in a medical facility of the Department under section 1710(a)(1) of this title, (ii) eligible for hospital or nursing home care in such a facility and receiving such care, (iii) receiving care

in a State home facility for which care the Secretary is paying per diem under section 1741 of this title, or (iv) transferred to a non-Department nursing home for nursing home care under section 1720 of this title and receiving such care; and

(B) who has a medical prognosis (as certified by a Department physician) of a life expectancy of six months or less.

(2) The term "hospice care services" means (A) the care, items, and services referred to in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and (B) personal care services.

(3) The term "hospice program" means any program that satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

(4) The term "medical facility of the Department" means a facility referred to in section 1701(4)(A) of this title.

(5) The term "non-Department facility" means a facility (other than a medical facility of the Department) at which care to terminally ill veterans is furnished, regardless of whether such care is furnished pursuant to a contract, agreement, or other arrangement referred to in section 1762(b)(1)(D) of this title.

(6) The term "personal care services" means any care or service furnished to a person that is necessary to maintain a person's health and safety within the home or nursing home of the person, including care or services related to dressing and personal hygiene, feeding and nutrition, and environmental support.

§ 1762. Hospice care: pilot program requirements

(a)(1) During the period beginning on October 1, 1993, and ending on December 31, 1998, the Secretary shall conduct a pilot program in order—

(A) to assess the feasibility and desirability of furnishing hospice care services to terminally ill veterans; and

(B) to determine the most efficient and effective means of furnishing such services to such veterans.

(2) The Secretary shall conduct the pilot program in accordance with this section.

(b)(1) Under the pilot program, the Secretary shall—

(A) designate not less than 15 nor more than 30 medical facilities of the Department at or through which to conduct hospice care services demonstration projects;

(B) designate the means by which hospice care services shall be provided to terminally ill veterans under each demonstration project pursuant to subsection (c);

(C) allocate such personnel and other resources of the Department as the Secretary considers necessary to ensure that services are provided to terminally ill veterans by the designated means under each demonstration project; and

(D) enter into any contract, agreement, or other arrangement that the Secretary considers necessary to ensure the provision of such services by the designated means under each such project.

(2) In carrying out the responsibilities referred to in paragraph (1) the Secretary shall take into account the need to provide for and conduct the demonstration projects so as to provide the Secretary with such information as is necessary for the Secretary to evaluate and assess the furnishing of hospice care services to terminally ill veterans by a variety of means and in a variety of circumstances.

(3) In carrying out the requirement described in paragraph (2), the Secretary shall ensure, to the maximum extent feasible, that—

(A) the medical facilities of the Department selected to conduct demonstration projects under the pilot program include facilities located in urban areas of the United States and rural areas of the United States;

(B) the full range of affiliations between medical facilities of the Department and medical schools is represented by the facilities selected to conduct demonstration projects under the pilot program, including no affiliation, minimal affiliation, and extensive affiliation;

(C) such facilities vary in the number of beds that they operate and maintain; and

(D) the demonstration projects are located or conducted in accordance with any other criteria or standards that the Secretary considers relevant or necessary to furnish and to evaluate and assess fully the furnishing of hospice care services to terminally ill veterans.

(c)(1) Subject to paragraph (2), hospice care to terminally ill veterans shall be furnished under a demonstration project by one or more of the following means designated by the Secretary:

(A) By the personnel of a medical facility of the Department providing hospice care services pursuant to a hospice program established by the Secretary at that facility.

(B) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a medical facility of the Department.

(C) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a non-Department medical facility.

(2)(A) The Secretary shall provide that—

(i) care is furnished by the means described in paragraph (1)(A) at not less than five medical facilities of the Department; and

(ii) care is furnished by the means described in subparagraphs (B) and (C) of paragraph (1) in connection with not less than five such facilities for each such means.

(B) The Secretary shall provide in any contract under subparagraph (B) or (C) of paragraph (1) that in-patient care may be provided to terminally ill veterans at a medical facility other than that designated in the contract if the provision of such care at such other facility is necessary under the circumstances.

(d)(1) Except as provided in paragraph (2), the amount paid to a hospice program for care furnished pursuant to subparagraph (B) or (C) of subsection (c)(1) may not exceed the amount that would be paid to that program for such care under section 1814(i) of the So-

cial Security Act (42 U.S.C. 1395f(i)) if such care were hospice care for which payment would be made under part A of title XVIII of such Act.

(2) The Secretary may pay an amount in excess of the amount referred to in paragraph (1) (or furnish services whose value, together with any payment by the Secretary, exceeds such amount) to a hospice program for furnishing care to a terminally ill veteran pursuant to subparagraph (B) or (C) of subsection (c)(1) if the Secretary determines, on a case-by-case basis, that—

(A) the furnishing of such care to the veteran is necessary and appropriate; and

(B) the amount that would be paid to that program under section 1814(i) of the Social Security Act would not compensate the program for the cost of furnishing such care.

§ 1763. Care for terminally ill veterans

(a) During the period referred to in section 1762(a)(1) of this title, the Secretary shall designate not less than 10 medical facilities of the Department at which hospital care is being furnished to terminally ill veterans to furnish the care referred to in subsection (b)(1).

(b)(1) Palliative care to terminally ill veterans shall be furnished at the facilities referred to in subsection (a) by one of the following means designated by the Secretary:

(A) By personnel of the Department providing one or more hospice care services to such veterans at or through medical facilities of the Department.

(B) By personnel of the Department monitoring the furnishing of one or more of such services to such veterans at or through non-Department facilities.

(2) The Secretary shall furnish care by the means referred to in each of subparagraphs (A) and (B) of paragraph (1) at not less than five medical facilities designated under subsection (a).

§ 1764. Information relating to hospice care services

The Secretary shall ensure to the extent practicable that terminally ill veterans who have been informed of their medical prognosis receive information relating to the eligibility, if any, of such veterans for hospice care and services under title XVII of the Social Security Act (42 U.S.C. 1395 et seq.).

§ 1765. Evaluation and reports

(a) Not later than September 30, 1994, and on an annual basis thereafter until October 1, 1999, the Secretary shall submit a written report to the Committees on Veterans' Affairs of the Senate and House of Representatives relating to the conduct of the pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. Each report shall include the following information:

(1) The location of the sites of the demonstration projects provided for under the pilot program.

(2) The location of the medical facilities of the Department at or through which hospice care services are being furnished under section 1763 of this title.

(3) The means by which care to terminally ill veterans is being furnished under each such project and at or through each such facility.

(4) The number of veterans being furnished such care under each such project and at or through each such facility.

(5) An assessment by the Secretary of any difficulties in furnishing such care and the actions taken to resolve such difficulties.

(b) Not later than August 1, 1997, the Secretary shall submit to the committees referred to in subsection (a) a report containing an evaluation and assessment by the Director of the Health Services Research and Development Service of the hospice care pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. The report shall contain such information (and shall be presented in such form) as will enable the committees to evaluate fully the feasibility and desirability of furnishing hospice care services to terminally ill veterans.

(c) The report shall include the following:

(1) A description and summary of the pilot program.

(2) With respect to each demonstration project conducted under the pilot program—

(A) a description and summary of the project;

(B) a description of the facility conducting the demonstration project and a discussion of how such facility was selected in accordance with the criteria set out in, or prescribed by the Secretary pursuant to, subparagraphs (A) through (D) of section 1762(b)(3) of this title;

(C) the means by which hospice care services are being furnished to terminally ill veterans under the demonstration project;

(D) the personnel used to furnish such services under the demonstration project;

(E) a detailed factual analysis with respect to the furnishing of such services, including (i) the number of veterans being furnished such services, (ii) the number, if any, of inpatient admissions for each veteran being furnished such services and the length of stay for each such admission, (iii) the number, if any, of outpatient visits for each such veteran, and (iv) the number, if any, of home-care visits provided to each such veteran;

(F) the direct costs, if any, incurred by terminally ill veterans, the members of the families of such veterans, and other individuals in close relationships with such veterans in connection with the participation of veterans in the demonstration project;

(G) the costs incurred by the Department in conducting the demonstration project, including an analysis of the costs, if any, of the demonstration project that are attributable to (i) furnishing such services in facilities of the Department, (ii) furnishing such services in non-Department facilities, and (ii) administering the furnishing of such services; and

(H) the unreimbursed costs, if any, incurred by any other entity in furnishing services to terminally ill veterans under the project pursuant to section 1762(c)(1)(C) of this title.

(3) An analysis of the level of the following persons' satisfaction with the services furnished to terminally ill veterans under each demonstration project:

(A) Terminally ill veterans who receive such services, members of the families of such veterans, and other individuals in close relationships with such veterans.

(B) Personnel of the Department responsible for furnishing such services under the project.

(C) Personnel of non-Department facilities responsible for furnishing such services under the project.

(4) A description and summary of the means of furnishing hospice care services at or through each medical facility of the Department designated under section 1763(a)(1) of this title.

(5) With respect to each such means, the information referred to in paragraphs (2) and (3).

(6) A comparative analysis by the Director of the services furnished to terminally ill veterans under the various demonstration projects referred to in section 1762 of this title and at or through the designated facilities referred to in section 1763 of this title, with an emphasis in such analysis on a comparison relating to—

(A) the management of pain and health symptoms of terminally ill veterans by such projects and facilities;

(B) the number of inpatient admissions of such veterans and the length of inpatient stays for such admissions under such projects and facilities;

(C) the number and type of medical procedures employed with respect to such veterans by such projects and facilities; and

(D) the effectiveness of such projects and facilities in providing care to such veterans at the homes of such veterans or in nursing homes.

(7) An assessment by the Director of the feasibility and desirability of furnishing hospice care services by various means to terminally ill veterans, including an assessment by the Director of the optimal means of furnishing such services to such veterans.

(8) Any recommendations for additional legislation regarding the furnishing of care to terminally ill veterans that the Secretary considers appropriate.

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PART III—READJUSTMENT AND RELATED BENEFITS

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CHAPTER 36—ADMINISTRATION OF EDUCATIONAL BENEFITS

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Subchapter II—Miscellaneous Provisions

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§ 3692. Advisory committee

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(c) The committee shall remain in existence until December 31, [1993.] *1997.*

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

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Subchapter IV—Administrative Matters

§ 7631. Periodic adjustments in amount of assistance

(a)(1) Whenever there is a general Federal pay increase, the Secretary shall increase the maximum monthly stipend amount, the maximum tuition reimbursement amount, [and] the maximum Selected Reserve [member] stipend [amount.] *amount, and the education debt reduction amount and limitation.* Any such increase shall take effect with respect to any school year that ends in the fiscal year in which the pay increase takes effect.

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(b) * * *

(1) * * *

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(4) The term "education debt reduction amount and limitation" means the maximum amount of assistance, and the limitation applicable to such assistance, for a person receiving assistance under subchapter VI of this chapter, as specified in section 7663 of this title and as previously adjusted (if at all) in accordance with this subsection.

[(4)] *(5)* The term "general Federal pay increase" means an adjustment (if an increase) in the rates of pay under the General Schedule under subchapter III of chapter 53 of title 5.

§ 7632. Annual report

Not later than March 1 of each year, the Secretary shall submit to Congress a report on the Educational Assistance *Program and the Education Debt Reduction* Program. Each such report shall include the following information:

(1) The number of students receiving educational assistance under the Educational Assistance [Program,] *Program and the Education Debt Reduction Program,* showing the numbers of students receiving assistance under the Scholarship [Program and] *Program,* the Tuition Reimbursement [Program] *Program, and the Education Debt Reduction Program* separately, and the number of students enrolled in each type of health profession training under each program.

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(3) The number of applications filed under each program, by health profession category, during the school year beginning in such year and the total number of such applications so filed for all years in which *each of* the Educational Assistance Program (or predecessor program) [has] *and the Education Debt Reduction Program have* been in existence.

(4) The average amounts of educational assistance provided per participant in the Scholarship [Program and] *Program,* per participant in the Tuition Reimbursement *Program, and per participant in the Education Debt Reduction* Program.

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§ 7636. Exemption of educational assistance payments from taxation

(a) Notwithstanding any other law, any payment to, or on behalf of a participant in the Educational Assistance Program, for tuition, education expenses, or a stipend under this chapter shall be exempt from taxation.

(b) Notwithstanding any other law, any payment on behalf of a participant in the Education Debt Reduction Program for the tuition or other costs referred to in section 7662(a)(4) of this title shall be exempt from taxation.

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Subchapter VI—Education Debt Reduction Program

§ 7661. Authority for program

(a) The Secretary shall carry out an education debt reduction program under this subchapter. The program shall be known as the Department of Veterans Affairs Education Debt Reduction Program (hereafter in this chapter referred to as the "Education Debt Reduction Program"). The purpose of the program is to assist personnel serving in health-care positions in the Veterans Health Administration in reducing the amount of debt incurred by such personnel in

completing educational programs that qualify such personnel for such service.

(b)(1) Subject to paragraph (2), assistance under the Education Debt Reduction Program shall be in addition to the assistance available to individuals under the Educational Assistance Program established under this chapter.

(2) An individual may not receive assistance under both the Education Debt Reduction Program and the Educational Assistance Program for the same period of service in the Department.

§ 7662. Eligibility; application

(a) An individual eligible to participate in the Education Debt Reduction Program is any individual (other than a physician or dentist) who—

(1) serves in a position in the Veterans Health Administration under an appointment under section 7402(b) of this title;

(2) serves in an occupation, specialty, or geographic area for which the recruitment or retention of an adequate supply of qualified health-care personnel is especially difficult (as determined by the Secretary);

(3) has pursued or is pursuing, as the case may be—

(A) a two-year or four-year course of education or training at a qualifying undergraduate institution which course qualified or will qualify, as the case may be, the individual for appointment in a position referred to in paragraph (1); or

(B) a course of education at a qualifying graduate institution which course qualified or will qualify, as the case may be, the individual for appointment in such a position; and

(4) owes any amount of principal or interest under a loan or other obligation the proceeds of which were used or are being used, as the case may be, by or on behalf of the individual to pay tuition or other costs incurred by the individual in the pursuit of a course of education or training referred to in paragraph (3).

(b) Any eligible individual seeking to participate in the Education Debt Reduction Program shall submit an application to the Secretary relating to such participation.

§ 7663. Agreement

(a) The Secretary shall enter into an agreement with each individual selected to participate in the Education Debt Reduction Program. The Secretary and the individual shall enter into such an agreement at the beginning of each year for which the individual is selected to so participate.

(b) An agreement between the Secretary and an individual selected to participate in the Education Debt Reduction Program shall be in writing, shall be signed by the individual, and shall include the following provisions:

(1) The Secretary's agreement to provide assistance on behalf of the individual under the program upon the completion by the individual of a one-year period of service in a position referred to in section 7662(a) of this title which period begins on the

date of the signing of the agreement (or such later date as is jointly agreed upon by the Secretary and the individual).

(2) The individual's agreement that the Secretary shall pay any assistance provided under the program to the holder (as designated by the individual) of any loan or other obligation of the individual referred to in section 7662(a)(4) of this title in order to reduce or satisfy the unpaid balance (including principal and interest) due on such loan or other obligation.

(3) The individual's agreement that assistance shall not be paid on behalf of the individual under the program for a year unless and until the individual completes the one-year period of service referred to in paragraph (1).

(4) The individual's agreement that assistance shall not be paid on behalf of the individual under the program for a year unless the individual maintains (as determined by the Secretary) an acceptable level of performance during the service referred to in paragraph (3).

§ 7664. Amount of assistance

(a) Subject to subsection (b), the amount of assistance provided to an individual under the Education Debt Reduction Program for a year may not exceed $4,000 (adjusted in accordance with section 7631 of this title).

(b) The total amount of assistance received by an individual under the Education Debt Reduction Program may not exceed $12,000 (as so adjusted).

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

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Subchapter III—State Home Facilities for Furnishing Domiciliary, Nursing Home, and Hospital Care

§ 8131. Definitions

For the purpose of this subchapter—

(1) * * *

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(3) The term "construction" means the construction of new domiciliary or nursing home buildings, the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary, nursing home, *adult day health,* or hospital care in State homes, and the provision of initial equipment for any such buildings.

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§ 8132. Declaration of purpose

The purpose of this subchapter is to assist the several States to construct State home facilities (or to acquire facilities to be used as State home facilities) for furnishing domiciliary or nursing home care to veterans, and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, *adult day health,* or hospital care to veterans in State homes.

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§ 8135. Applications with respect to projects; payments

(a) * * *

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(b)(1) * * *

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(2) * * *

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(C) An application from a State which the Secretary determines, in accordance with criteria and procedures specified in regulations which the Secretary shall prescribe, has a greater need for nursing home or domiciliary beds *or adult day health care facilities* than other States from which applications are received.

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(3) In according priorities to projects under paragraph (2) of this subsection, the Secretary—

(A) shall accord priority only to projects which would involve construction or acquisition of either nursing home or domiciliary [buildings;] *buildings or construction (other than new construction) of adult day health care buildings;* and

(B) may not accord any priority to a project which would expand a State's capacity to furnish hospital care in a State home.

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VETERANS HEALTH CARE ACT OF 1992

(Public Law 102–585, November 4, 1992)

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TITLE I—WOMEN VETERANS HEALTH PROGRAMS

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SEC. 102. SEXUAL TRAUMA COUNSELING.

(a) * * *

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[(b) TRANSITION PROVISION.—In the case of a veteran who was discharged or released from active military, naval, or air service before December 31, 1991, the two-year period specified in section

1720D(a)(2) of title 38, United States Code, as added by subsection (a), shall be treated as ending on December 31, 1993.]

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SEC. 106. HEALTH CARE SERVICES FOR WOMEN.

[(a) GENERAL AUTHORITY.—In furnishing hospital care and medical services under chapter 17 of title 38, United States Code, the Secretary of Veterans Affairs may provide to women the following health care services:

(1) Papanicolaou tests (pap smears).

(2) Breast examinations and mammography.

(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.

(b) RESPONSIBILITIES OF DIRECTORS OF FACILITIES.—] The Secretary shall ensure that directors of medical facilities of the Department identify and assess opportunities under the authority provided in title II of this Act to (1) expand the availability of, and access to, health care services for women veterans under sections 1710 and 1712 of title 38, United States Code, and (2) provide counseling, care, and services authorized by this title.

SEC. 107. REPORT ON HEALTH CARE AND RESEARCH.

(a) * * *

(b) CONTENTS.—The report subsection (a) shall include the following information with respect to the most recent fiscal year before the date of the report:

(1) The number of women veterans who have received services described in section 106 of this Act *and women's health services (as such term is defined in section 1701(10) of title 38, United States Code)* in facilities under the jurisdiction of the Secretary (or the Secretary of Defense), shown by reference to the Department facility which provided (or, in the case of Department of Defense facilities, arranged) those services;

(2) A description of (A) the services provided at each such facility, [and] (B) *the type and amount of services provided by such personnel, including information on the numbers of inpatient stays and the number of outpatient visits through which such services were provided, and (C)* the extent to which each such facility relies on contractual arrangements under section 1703 or 8153 of title 38, United States Code, to furnish care to women veterans in facilities which are not under the jurisdiction of the Secretary where the provision of such care is not furnished in a medical emergency.

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(4) A description of the personnel of the Department who provided such services to women veterans, including the number of employees (including both the number of individual employees and the number of full-time employee equivalents) and the professional qualifications or specialty training of such employees

and the Department facilities to which such personnel were assigned.

(5) A description of any actions taken by the Secretary to ensure the retention of the personnel described in paragraph (4), and any actions undertaken to recruit additional such personnel or personnel to replace such personnel.

(6) An assessment by the Secretary of any difficulties experienced by the Secretary in the furnishing of such services and the actions taken by the Secretary to resolve such difficulties.

[(4)] *(7)* A description (as of October 1 of the year preceding the year in which the report is submitted) of the status of any research relating to women veterans being carried out by or under the jurisdiction of the Secretary, including research under section 109 of this Act.

(8) A description of the actions taken by the Secretary to foster and encourage the expansion of such research.

SEC. 108. COORDINATION OF SERVICES.

(a) The Secretary of Veterans Affairs shall ensure that an official in each regional office of the Veterans Health Administration shall serve as a coordinator of women's services. The responsibilities of such official shall include the following:

(1) Conducting periodic assessments of the needs for services of women veterans within such region.

(2) Planning to meet such needs.

(3) Assisting in carrying out the purposes of section 106(b) of this title.

(4) Coordinating the training of women veterans coordinators who are assigned to Department facilities in the region under the jurisdiction of such regional coordinator.

(5) Facilitating communication between women veterans coordinators under the jurisdiction of such regional coordinator and the Under Secretary for Health and the Secretary.

[(5)] *(6)* Providing appropriate technical support and guidance to Department facilities in that region with respect to outreach activities to women veterans.

(b) Each official who serves in the position of coordinator of women's services under subsection (a) shall so serve on a full-time basis.

SEC. 109. RESEARCH RELATING TO WOMEN VETERANS HEALTH.

(a) INITIATION AND EXPANSION OF RESEARCH.—*(1)* The Secretary of Veterans Affairs, in carrying out the Secretary's responsibilities under section 7303 of title 38, United States Code, shall foster and encourage the initiation and expansion of research relating to the health of [veterans who are women.] *women veterans.*

(2) In carrying out this section, the Secretary shall consult with the following:

(A) The Director of the Nursing Service.

(B) Officials of the Central Office assigned responsibility for women's health programs and sexual trauma services.

(C) The members of the Advisory Committee on Women Veterans established under section 542 of title 38, United States Code.

(D) Members of appropriate task forces and working groups within the Department of Veterans Affairs (including the

(D) Members of appropriate task forces and working groups within the Department of Veterans Affairs (including the Women Veterans Working Group and the Task Force on Treatment of Women Who Suffer Sexual Abuse).

(3) The Secretary shall foster and encourage research under this section on the following matters as they relate to women.

(A) Breast cancer.

(B) Gynecological and reproductive health, including gynecological cancer, infertility, sexually-transmitted diseases, and pregnancy.

(C) Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

(D) Mental health, including post-traumatic stress disorder and depression.

(E) Diseases related to aging, including menopause, osteoporosis, and Alzheimer's Disease.

(F) Substance abuse.

(G) Sexual violence and related trauma.

(H) Exposure to toxic chemicals and other environmental hazards.

(4) The Secretary shall, to the maximum extent practicable, ensure that personnel of the Department of Veterans Affairs engaged in the research referred to in paragraph (1) include the following:

(A) Personnel of the geriatric research, education, and clinical centers designated pursuant to section 7314 of title 38, United States Code.

(B) Personnel of the National Center for Post-Traumatic Stress Disorder established pursuant to section 110(c) of the Veterans Health Care Act of 1984 (Public Law 98–528; 98 Stat. 2692).

(5) The Secretary shall, to the maximum extent practicable, ensure that personnel of the Department engaged in research relating to the health of women veterans are advised and informed of such research engaged in by other personnel of the Department.

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SEC. 110. POPULATION STUDY OF WOMEN VETERANS.

(a) STUDY.—(1) The Secretary, subject to subsection (d), shall conduct a study to determine the needs of veterans who are women for health-care services. [The study shall be based on an appropriate sample of veterans who are women.]

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[(3) In carrying out the study, the Secretary shall include in the sample veterans who are women and members of the Armed Forces serving on active duty who are women.]

(3)(A) Subject to subparagraph (B), the study shall be based on—

(i) an appropriate sample of veterans who are women and of women who are serving on active military, naval, or air service; and

(ii) an examination of the medical and demographic histories of the women comprising such sample.

(B) The sample referred to in subparagraph (A) shall, to the maximum extent practicable, constitute a representative sampling (as determined by the Secretary) of the ages, the ethnic, social and eco-

nomic backgrounds, the enlisted and officer grades, and the branches of service of all veterans who are women and women who are serving on such duty.

(C) In carrying out the examination referred to in subparagraph (A)(ii), the Secretary shall determine the number of women of the sample who have used medical facilities of the Department, nursing home facilities of or under the jurisdiction of the Department, and outpatient care facilities of or under the jurisdiction of the Department.

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